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IMS

1850-2000

50 Years

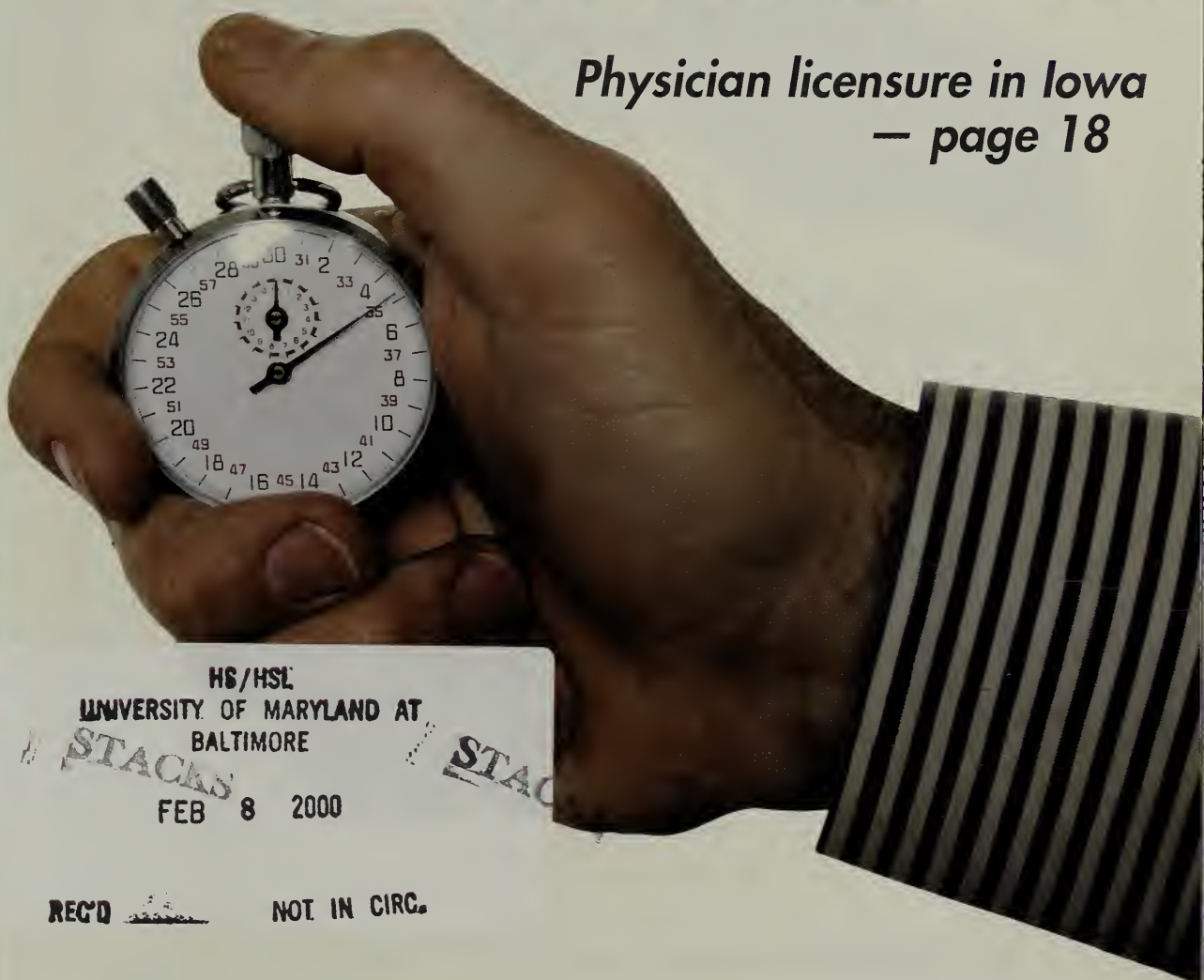
Iowa Medicine

January/February 2000

An Iowa Medical Society publication

Ready, set . . . **WAIT**

*Physician licensure in Iowa
— page 18*



IMS to join Medicare lawsuit / page 9

Antibiotic resistance is a critical issue here / page 12

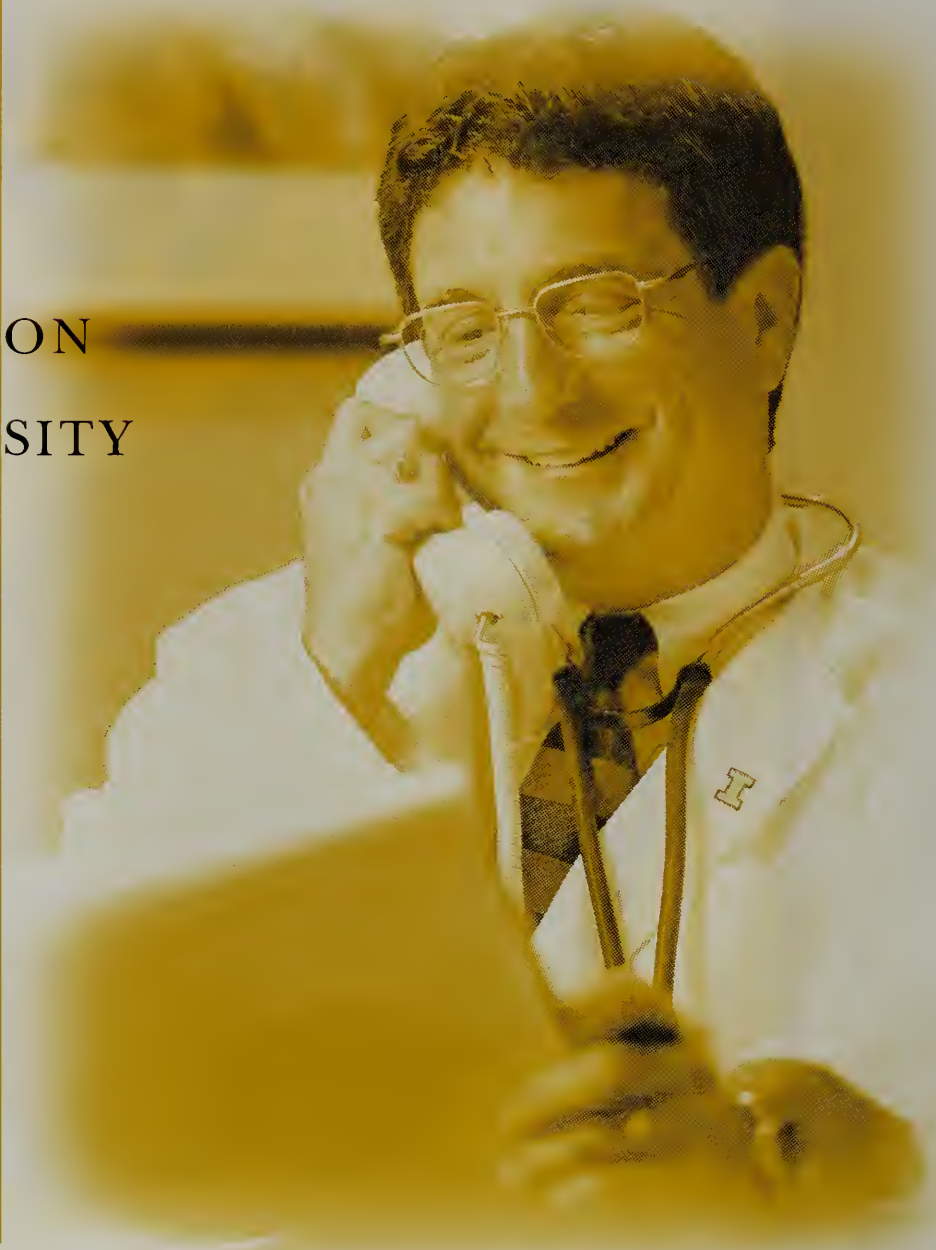
Place your nominations for IMS offices / page 16

AMA launches National House Call / page 25

Yes, Iowa physicians watch ER! (special insert)

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Iowa Medicine

Published by the Iowa Medical Society

January/February 2000

Vol. 90/1

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Join us April 14-16 for the Iowa Medical Society's 150th birthday party.

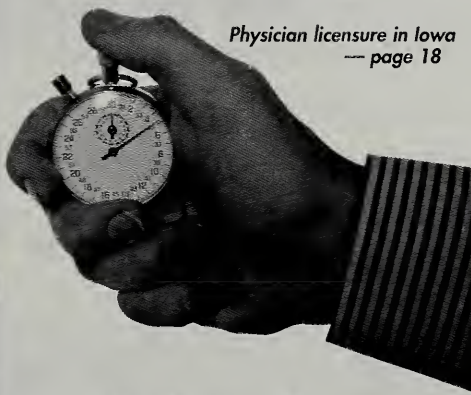
IMS
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150 Years
OF
CARING
FOR
IOWANS
IOWA MEDICAL SOCIETY
SEVENTH AVENUE
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Yes, Iowa physicians watch ERI (special insert)

This month's feature:

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... IMS passed HIV/AIDS & state medical examiner bills?

... IMS killed the Group B strep bill?

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Action Committee WAS there!**

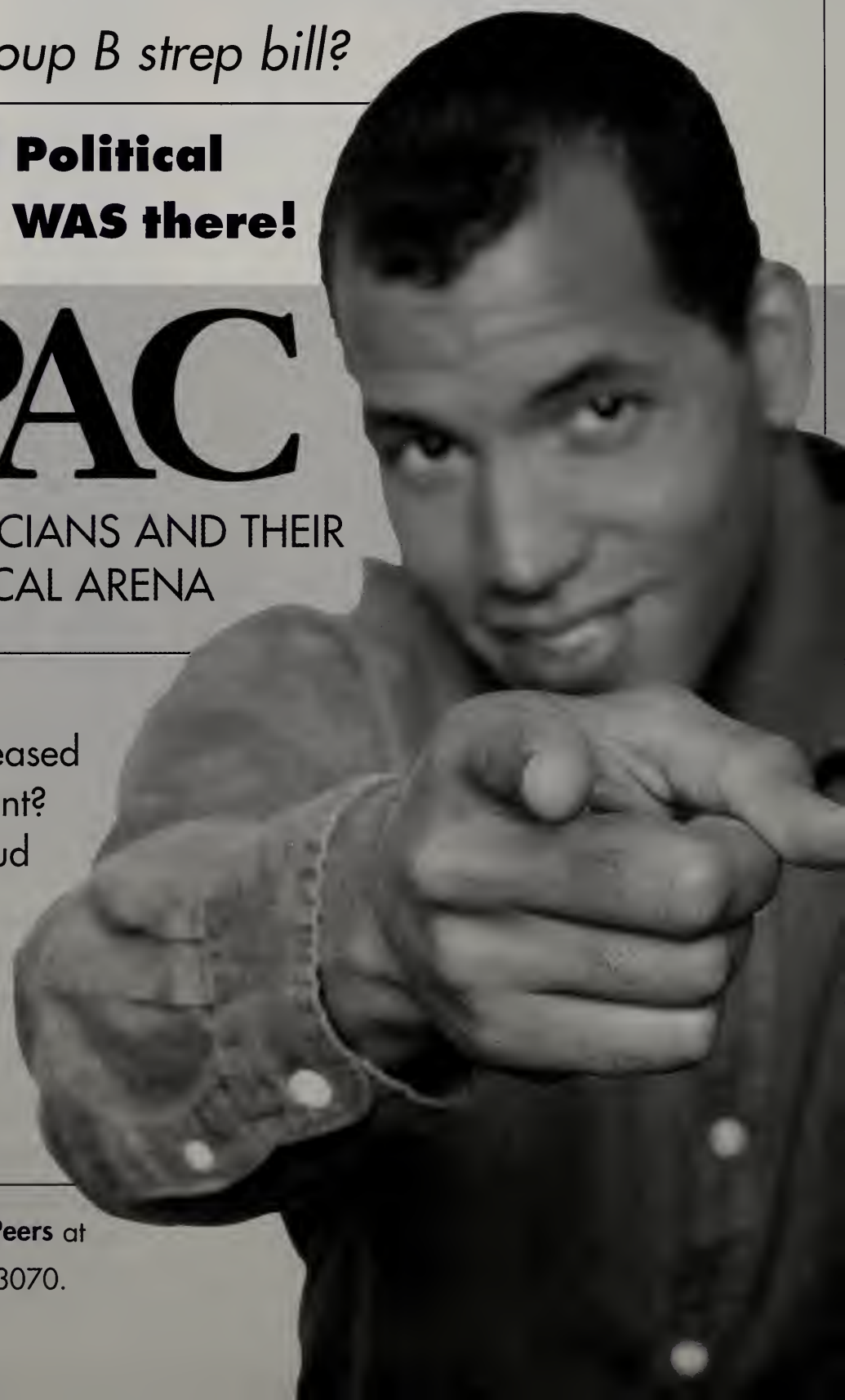
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PATIENTS IN THE POLITICAL ARENA

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HEALTH CARE ISSUES — Voters ARE WORRIED



Health care must be at the top of the next president's policy agenda.

by Siroos Shirazi, MD

In a recent *Washington Post* poll, health care concerns were listed as three of the top five worries among American voters. The number one concern was that insurance companies — not doctors — are deciding medical treatment. In this election year, we need to push political candidates to debate these issues that concern our patients.

AMA, along with state and local medical associations, intends to jump-start dialogue among presidential candidates on health policy.

I recently returned from Washington, DC after participating in the kick-off of the AMA's National House Call initiative. The aim of

National House Call is to raise the visibility of health policy issues and engage voters and candidates in the 2000 presidential campaign trail. The National House Call urges candidates to answer six questions (*see box*) for voters. AMA leadership promised to be available in every primary to draw attention to health care issues.

We also need to keep these same questions in mind for our congressional candidates to see how they rate among other candidates.

We need to go to voting booths and vote for a candidate who is endorsing a true Patients' Bill of Rights, similar to the one passed by the House and not the Senate.

We need to support a candidate who has a workable plan to improve Medicare and cover the 44 million Americans who are uninsured.

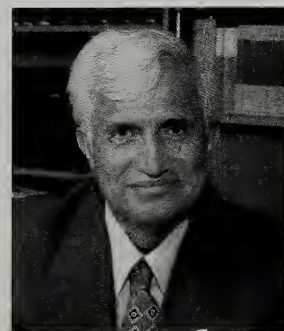
I was 41 years-old when I became a U.S. citizen and earned the privilege to vote

BEFORE YOU VOTE —

1. Does your candidate support a meaningful Patients' Bill of Rights?
2. Does your candidate believe physicians, not insurance plans, should determine what care is medically necessary for their patients?
3. Does your candidate believe that HMOs should be held accountable for treatment decisions that harm patients?
4. Does your candidate support health insurance coverage for all Americans?
5. Does your candidate support tax-based incentives to make it easier for American families to afford health insurance?
6. Does your candidate have a plan to reform Medicare?

in America. In my native country, I could vote at age 18, but unfortunately an individual's vote rarely counted. You could vote for anyone you desired, but the government would select who it wanted.

In America, every vote counts! Voting, for me, is a duty and a pleasurable right. It astonishes me that all Americans do not get involved in political debate and exercise their right to vote for a candidate who they feel represents their values.



Dr. Shirazi is a general surgeon at the University of Iowa Hospitals and Clinics and president of the Iowa Medical Society.

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CME/travel programs:
Call Intrav at (800) 825-2900.

Financial & retirement planning:
Call FCM at (800) 798-1012 or visit www.fostercapital.com

All other services:
Call Ed Whitver at IMS headquarters (800) 747-3070.

IMS

IOWA MEDICAL SOCIETY
Working for Iowa physicians and their patients

PERTUSSIS on the rise in Iowa

Iowa health officials continue to see a sharp increase in pertussis. They're asking doctors to be more vigilant and prevent more cases from occurring.

Nearing the end of the year, Iowa had 67 confirmed cases and another 54 suspected cases. Over the past three years, Iowa has had nearly 400 cases, the most in any three year period since the early 1960s.

Advertising directly to consumers — IT WORKS

Why do pharmaceutical companies spend millions of dollars advertising on television and in magazines? Because direct-to-consumer ads work.

New research shows that patients are asking physicians for information and prescriptions for particular medications more aggressively and consistently. Even more significant, physicians are going along with patient requests by prescribing the drugs more than 30 percent of the time.

Patricia Quinlisk, MD, state epidemiologist, says because most children and adults have been vaccinated, they assume they're protected. Also, the current vaccine

for infants doesn't provide life-long protection.

Dr. Quinlisk asks physicians to consider pertussis when seeing patients with persistent, unexplained cough.

Half of Americans are OVERWEIGHT

FACTS ABOUT OBESITY



- Total cases of obesity (30 percent above ideal body weight): 12 percent in 1991 increased to 17.9 percent in 1998.
- Physical inactivity is still a major contributor to obesity. This barely changed from 1991 to 1998.
- An estimated 280,000 deaths annually are attributed to obesity.
- More than half of American adults are overweight or obese (63 percent men and 55 percent women aged 25 years or older).
- High blood pressure is the most common overweight- and obesity-related health condition.

Facts excerpted from JAMA October 21, 1999

Smoking MOTHERS in Des Moines

Des Moines has a greater percentage of mothers who smoked during pregnancy in 1997 than any of America's largest cities, according to a report from the Annie E. Casey Foundation in Baltimore.

Nearly 24 percent of the 3,406 babies born in Des Moines in 1997 had mothers who smoked while pregnant.

Stephen Gleason, DO, director of the Iowa Department of Public Health, said the problem was recently brought to his attention. He said his department is working on a program to address the issue, regardless of whether or not tobacco settlement money is available for any future programs.

THROCKMORTON SURGICAL SOCIETY

IOWA CHAPTER - AMERICAN COLLEGE OF SURGEONS

and

IOWA ACADEMY OF SURGERY

ANNUAL SPRING MEETING

SURGICAL SYMPOSIUM ON ONCOLOGIC SURGERY

APRIL 14-15, 2000

**Iowa Methodist Medical Center - Education Center
1415 Woodland Avenue
Des Moines, Iowa**

THROCKMORTON SURGICAL SOCIETY FACULTY (Friday - April 14)

Jay L. Grosfeld, M.D., FACS

University of Indiana School of Medicine
Riley Hospital for Children

Merrick I. Ross, M.D., FACS

University of Texas M.D. Anderson Cancer Center

Daniel R. Kollmorgen, M.D.

Iowa Methodist Medical Center

Mark S. Roh, M.D., FACS

Pittsburgh-Allegheny Hospital

James G. Blythe, M.D., FACS

Gynecologic Oncology Surgical Services
Central Iowa Health System

Peter Jochimsen, M.D., FACS

The University of Iowa College of Medicine

THROCKMORTON SURGICAL SOCIETY TOPICS (Friday - April 14)

Skin Sparing Mastectomy

Developments in Management of Cutaneous Melanoma

Liver Tumors in Children

Neuroblastoma and Wilms' Tumor

Management of Esophageal Cancer

Breast Cancer: A Century of Progress Leading to the Millenium

Update in Gyn/Onc Surgery

Technical Aspects of Liver Resection

Gene Therapy and Liver Tumors

Update on Soft Tissue Sarcomas

Surgery for Primary and Secondary Liver Cancer

IOWA ACADEMY OF SURGERY/AMERICAN COLLEGE OF SURGEONS – IOWA CHAPTER

(Saturday - April 15, 2000)

Presentation of Surgery Resident Paper Competition and following speakers and topics:

James G. Blythe, M.D., FACS

Michael Foley, M.D.

Robert M. Kuhl, M.D., FACS

Philip Caropreso, M.D., FACS

A Case of Rectal Carcinoma with Extensive Colonic

Polyposis and Surgical Treatment Options

Ovarian Tumors and the General Surgeons

Difficult and Interesting Complex Cases at a County
Hospital

Chronic Abscess suprapubic Area Abdominal Wall

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IMS to support Medicare LAWSUIT

The Iowa Medical Society Executive Committee has voted to financially support a lawsuit against Medicare which has been filed in the Minnesota federal district court.

Plaintiffs in the suit are the Minnesota attorney general, and the Minnesota Senior Federation, a local nonprofit organization representing seniors. The Iowa Hospital Association is also financially backing the lawsuit.

The suit is filed on behalf of Mary Sarno, a Medicare beneficiary who lives in Florida and wants to relocate to Minnesota to be near her daughter. However, she cannot relocate because the Medicare managed care system in Minnesota does not cover \$800 in prescription medicines which are covered

by her Florida HMO.

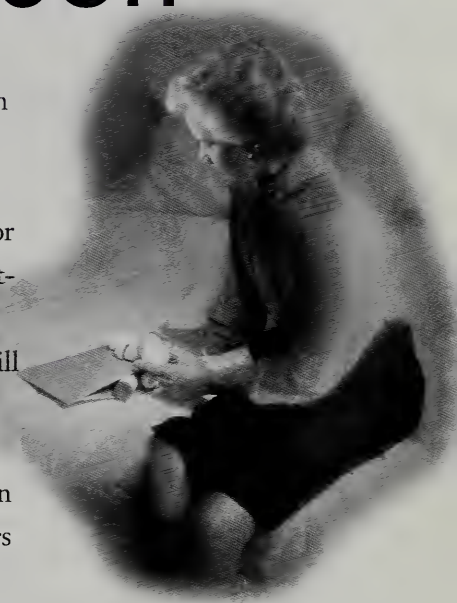
According to Jeanine Freeman, JD, IMS vice president of public policy and advocacy, the suit is based on three constitutional arguments: violation of states' rights by requiring the state to meet financial obligations not being met by the federal government; violation of the equal protection clause by treating similarly situated members of a class differently; and violation of a citizen's right to travel among states.

The national press appears to give the greatest emphasis to the right to travel argument.

The lawsuit seeks no damages. Rather, the suit asks the court to declare the current Medicare managed care payment system illegal and to prohibit the federal govern-

ment from continuing to make Medicare payments in a way that violates the constitution.

In a legal analysis done for the IMS Executive Committee, Ms. Freeman said she does not believe the case will be seen as frivolous but its arguments are novel and anyone challenging a law on constitutional grounds bears a heavy burden of legal proof.



Go figure

"Apparently, we have an anti-trust law that will allow Exxon and Mobil to merge but won't allow two physicians to present a united front on behalf of their patients."

Rep. Tom Campbell, California Republican and author of the anti-trust relief bill, in remarks to the AMA House of Delegates in December

IMMUNIZATIONS by pharmacists

The Iowa Board of Pharmacy Examiners and the Iowa Board of Medical Examiners continue to work on draft rules on immunizations by pharmacists. The rules address only flu and pneumovax vaccines for adults. First draft pharmacy rules would require

pharmacists to administer immunizations under the authorization of a physician under written protocol. The authorizing physician must be located within 30 miles of the pharmacist and the physician must be notified of problems experienced by the person immunized. Records

must be kept by the pharmacist. The BME rules will address the responsibilities of the supervising physician. The IMS has been extremely active on the issue of pharmacist immunizations, emphasizing the need for physician delegation allowing only adult flu and pneumonia immunizations.

The Pharmacy Board rejected the first pharmacy draft, saying the rules were too burdensome.

Y2K General

Assembly **CALL** to action

The Iowa General Assembly convenes for its second year of the 78th Session. All bills introduced in 1999 remain eligible for debate.

MEDICAID REIMBURSEMENT

IMS is asking for physician payment at Medicare levels and a RBRVS Medicaid payment methodology. Physician payment under Medicaid is so low that many physicians lose money on Medicaid patient visits. IMS, IAFP, AAP (Iowa Chapter), ACOG (Iowa Section), IMS neonatal physicians and IOMA have formed a physician-based coalition to lobby Iowa lawmakers. IMS continues its advocacy with the governor, legislative leadership and key committees. *Every lawmaker must hear from physicians on this issue!*

TOBACCO SETTLEMENT

IMS supports dedication of all of Iowa's tobacco settlement dollars to health care. The legislature must decide how the first two-years of tobacco settlement dollars — \$137 million — will be spent in fiscal year 2001. IMS recommendations include support of a comprehensive tobacco prevention and con-

trol program and augmentation of Medicaid provider payments. The IMS tobacco settlement subcommittee of the Committee on Public Health invites physician participation in a speakers' bureau and other advocacy actions on this issue. *Join the IMS Tobacco Advocacy Team! Call Jen Davis at the IMS (800) 747-3070.*

CERTIFICATE OF NEED

A task force of the Department of Public Health, convened at the direction of the General Assembly to look at the relevancy of Iowa's CON law, recommended no change to CON. The task force voted down IMS' proposal to repeal the law and IMS' option to exempt outpatient surgical facilities in communities of 20,000 or more from CON review. The report will go to the legislature.

STATE MEDICAL EXAMINER

Julia Goodin, MD, the new state medical examiner, assumed her duties in December. A new deputy MD has not yet been hired. The state ME budget of \$10 million, including request for a new facility, faces significant appropriation hurdles.

MENTAL HEALTH PARITY

The insurance industry has taken several months to debate and draft a mandated mental health parity bill for biological-based mental health diagnosis. The bill emphasizes a managed care model with yearly benefit limits of 30 inpatient and 52 outpatient days. This parity draft would apply only to large group policies and would not include substance abuse. The business community is in opposition to any form of mandated mental health parity.

LAW MIDWIFERY

The General Assembly directed a study on whether direct-entry (lay) midwives should be licensed or certified in Iowa. Current law authorizes midwifery only through nurse midwives. A scope of practice review committee will make its final recommendations in January. The committee does not support the broad-based application of lay midwives, which included prescriptive authority and ordering of tests. IMS testified in strong opposition to state approval of non-medically trained midwives and the increased risk to maternal and infant morbidity and mortality.

Physician payment under Medicaid is so low that many physicians lose money on Medicaid patient visits.

IMS

Michael Abrams
Executive Vice President

Jeanine Freeman, JD
Vice President of Public Policy

Jennifer Davis
Coordinator of Public Policy
Communications/Lobbyist

Denise Hill, JD
Manager of Public and
Regulatory Affairs

Sheryl Nuzum
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Cheryl Peers
Administrative Assistant

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West Des Moines, Iowa 50265
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YES, YOU WATCH ER

You like to surf (at home) . . .

An impressive 62% of over-all respondents say they surf the net at home, with the under 40 age group even higher at 74% and 66% of those 41-50 home surfing. About 62% of family physicians say they surf at home.



Specialists who are hard-core surfers include plastic surgeons, oncologists and otolaryngologists.

For a list of non-medical sites most often visited by physicians, see the other side of this report.

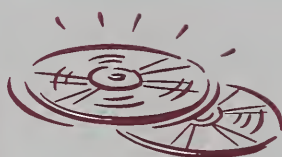
But you're less likely to shop on-line

Not all Iowa physicians have warmed to the idea of shopping on line. Of 310 respondents, 36% say they shop on-line.



Physicians in the 41-50 age group (45%) are most likely to shop on-line; physicians age 61-74 the least likely at 34%.

How do Iowa physicians get information?



The Iowa Medical Society asked Iowa physicians how they get information and how they prefer to

communicate; 310 of you returned our survey. Respondents represented 29 specialties and subspecialties. Of respondents who stated their age, 21% were under 40; 35% were 41-50; 26% were 51-60; and 9% were 61-74.

For clinical research, it's back-to-basics

What resources do Iowa physicians consult first for clinical information? Resource books were named most often by physicians in all age groups.

Surprisingly, physicians in the under 40 age group are no more likely than their older colleagues to consult the Internet on clinical matters. Specialty society journals are named by 50-70% of physicians in all specialties as a source of clinical information. *New England Journal of Medicine*, *JAMA* and the *Annals of Internal Medicine* were read most frequently by all specialties. Other sources of clinical information listed by respondents included colleagues, specialists, CD ROM, meetings and CME seminars.



Iowa physicians like shows about doctors, lawyers and cops.



With no trends dictated by specialty . . . *ER*, *The Practice*, *Law & Order* and *NYPD Blue* are named most often in our survey as "shows you watch when you have time." Most popular channels? CNN, CNBC, ESPN, Discovery, A&E, the History Channel, PBS and TLC. Oh, and you like to watch videos.

What's black and white and read all over by Iowa physicians?

Iowa physicians are big newspaper readers. Percentages ranging from 72% of those under age 40 to 93% of those over age 60 say the newspaper is their preferred way to keep up on current events. Those under age 40 also use television almost as frequently as the newspaper. An unexpected trend? Physicians in the over 60 group are most likely to get news from the Internet (31%).



IMS

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Working for Iowa physicians and their patients

Newsweek tops list of favorite magazines

Newsweek, *Time* and *Sports Illustrated* are mentioned by the largest number of physicians as their preferred non-medical magazines. Other magazines with a significant readership among Iowa physicians are: *US News and World Report*, *Scientific American*, *Smithsonian*, *National Geographic*, *Consumer Reports*, *Money*, *Forbes*, *Gourmet*, *Runner's World*

You've got (e)mail!

Of physicians in all age groups, 43% say they use email to communicate at work. Physicians over 40 are more likely to use office email. This is opposite of the expected trend and may

have more to do with availability than with conscious choice.



Thank you to the 310 physicians who answered our survey. Thank you, also, to the 79% of respondents who said they read *Iowa Medicine* and the *IMS Advocate*!

A report on the IMS communications survey

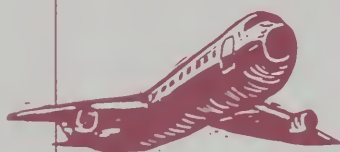
When it comes to surfing, it's a bull market

Web sites about the stock market and personal financial issues dominate the list of non-medical sites named by Iowa physicians who surf the net at home. Smartmoney, E-trade and Dow Jones Interactive are mentioned by multiple physicians. Sites about travel, current events, cars, physical fitness, astronomy, motorcycles, wine and pets are also popular. Even Martha Stewart's web site got a mention.



A few of the web sites listed in the IMS survey . . .

MSNinvestor
Pathfinder.com
Travelcity.com
Mapquest
CME (Chicago Mercantile)
Smartmoney
MotleyFool (financial)
Quote.com
Stockmaster.com
Dowtheory
Pet Warehouse
Ebay



Under 50? You prefer fiction

Physicians under 50 are more interested in reading fiction, while physicians over 50 show a marked preference for history and biography. Physicians in the middle two age groups (41-60) are much more interested in self-help books. Relatively few physicians of any age (an average of about 16%) say they choose medical books for recreational reading.



Iowa physicians are tuned in!

Eighty percent of Iowa physicians tune into music or news on the radio while driving a car. Physicians age



50 and younger are more likely to listen to personal or professional development tapes. Fewer than 10% of physicians under age 60 say they listen to novels on tape and physicians over age 61 (41%) are more likely to listen to CDs. Of all age categories, a total of 62% say they spend 1-5 hours a week in their cars; 33% drive 6-10 hours a week. If anyone out there is still listening to 8-tracks, they are keeping it a secret!

Keep those cards and letters coming!

Direct mail remains the choice of 65% of physicians in all age groups as how they want to be communicated with. Fax and email tied as the second best ways to reach Iowa physicians.



Reporting IMPAIRED drivers



Keeping the roads safe can mean making a tough call for your patient.

by Jeanine Freeman, JD

The AMA Council on Judicial and Ethical Affairs (CEJA) submitted a redrafted opinion to the AMA House of Delegates on the ethical obligations of a physician to report impaired drivers to the state's Department of Transportation (DOT). The AMA approved the changes.

REPORTING OBLIGATION

Iowa law does not require but does permit a physician to report patients with physical or mental impairments which would interfere with their ability to safely operate a motor vehicle. CEJA's opinion is similar: Physicians have an "ethical responsibility to assess patients' physical or

mental impairments that might adversely affect driving abilities."

CEJA has guidelines to assist physicians in evaluating and reporting. Where "clear evidence of substantial impairment implies a strong threat to patient and public safety and where the physician's advice to discontinue driving is ignored," it is then "desirable and ethical" for physicians to report. Physicians are to use their best judgment.

BEFORE REPORTING

Iowa law requires physicians to make a reasonable effort to notify the patient in writing that a report will be made. Before reporting, CEJA says physicians must identify and document the physical or mental impairment which relates to the inability to drive without risking public safety; make efforts to inform patients and their families of options; and should disclose and explain the physician's responsibility to report.

WHAT TO REPORT

Iowa law does not list specifics on reporting, but CEJA gives solid advice: Report only minimal information needed to address the impairment. Reports to the DOT are confidential.

IMMUNITY

Iowa law grants immunity from civil and criminal liability for reporting. Furthermore, Iowa law makes it clear physicians have no duty to make a report or to warn third parties regarding the patient's impairment.

The DOT has the responsibility to determine if the person can safely drive. Physician reports should avoid conclusions except in unusual circumstances. If a physician's report states the patient's condition makes it unsafe for the patient to drive, DOT likely will suspend the patient's driving privileges pending further review.

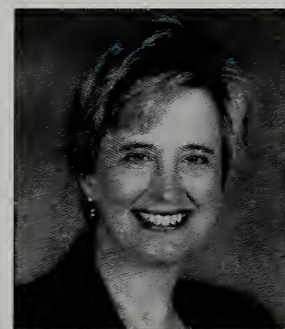
Report to:

Iowa Department of Transportation
Office of Driver Services
152 Collins Road NE
Cedar Rapids, IA 52402

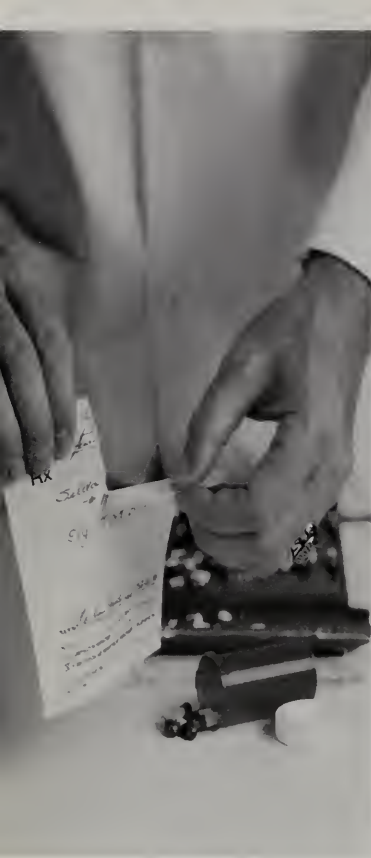
— or —

Park Fair Mall
100 Euclid Avenue • PO Box 9204
Des Moines, IA 50306-9204

Please note: The confidentiality restrictions of federal substance abuse laws prevail over Iowa law.



Jeanine Freeman is vice president of public policy and advocacy for the Iowa Medical Society. Information in this column is not intended to be legal advice. Call your attorney with specific questions or concerns.



Antibiotic *resistance:* a CRITICAL ISSUE in Iowa

Antibiotics should not be the accepted or expected treatment for most upper respiratory infections.

by Lisa Veach, MD

In Iowa, 37 percent of streptococcus pneumoniae isolates display intermediate or high level resistance to penicillin. The problem of antibiotic resistance is now a critical issue for many bacterial pathogens.

In January of 1998, a task force was convened by the Iowa Department of Public Health to evaluate the prevalence of antibiotic resistance and develop strategies to diminish the risk.

A statewide system to monitor trends in antibiotic resistance was identified as a key need, and the Iowa Antibiotic Resistance Surveillance Program (IARSP) was established.

This program serves to

track antibiotic resistance and is a gold standard reference laboratory for quality assurance for hospital laboratories. The program focuses on invasive *Streptococcus pneumoniae*, VRE, MRSA, vancomycin resistant or intermediate *S. aureus* and invasive group A streptococci. Each facility submits these organisms to the University Hygienic Laboratory.

The report of the task force contains two other areas of focus:

1. Infection control measures: The report provides recommendations for the following settings: primary care, acute care, long term care, home health/hospice, hemodialysis, schools, daycare and veterinary medicine.

2. Antibiotic use: The report emphasizes the importance of judicious use of antibiotics in all settings. Optimal use of antibiotics will require behavior changes in the medical community and the public. In the outpatient setting, overuse of antibiotics for upper respiratory infec-

tions (most of which are viral) is common. Work is underway to develop better diagnostic tests to distinguish viral from bacterial but for most upper respiratory infections, antibiotics should not be the accepted or expected treatment. Changing patient expectations is the goal of posters and brochures included in a packet sent to 6,500 Iowa health care professionals.

The following general guidelines for antibiotic use are provided in the report.

- Restrict use to patients with bacterial infections.
- Choose the narrowest-spectrum antibiotic possible.
- Follow established institutional guidelines.
- Reserve long term and perioperative antimicrobial prophylaxis for specific conditions where the benefit/risk ratio has been established.
- Refrain from using antibiotics as an antipyretic.
- Take time to educate when a patient demands an antibiotic for a viral illness.
- Take measures to ensure proper use of antibiotics.

IMS members can get a copy of the task force's full report (including 15 pages of strategies for reducing risk of antibiotic resistance in health care settings) by calling 888-398-9696.

Dr. Lisa Veach is a member of the Iowa Department of Public Health Task Force on Antibiotic Resistance. She is a Des Moines internist specializing in infectious diseases.

IOWA PHYSICIAN distinctions & AWARDS

NANCY ANDREASEN, MD, received the Health ROI award from the National Institute of Health.

CAROL SCOTT-CONNER, MD, has been selected to serve on a national committee charged with "Creating a vision for space medicine during travel beyond Earth's orbit."

MERCY MEDICAL CENTER is creating the Frederick and Ann Katzman Breast Center. The center will specialize in diagnostic breast health care.

FRANCOIS ABBOUD, MD, has received the American Heart Association's 1999 Research Achievement Award.

HAROLD ADAMS, MD, and **DONALD HEISTAD, MD**, received special recognition from the American Heart Association for their research on stroke and heart disease.

MERCY MEDICAL CENTER-DES MOINES has been named a National Research Corporation Consumers Choice, Heart Services award winner.

GERALD MCGOWAN, MD, has been named the 1999 Medical Educator of the Year award by the Academy of Family Physicians.

DONALD SKINNER, MD, was named the 1999 Family Physician of the Year.

CHUCK HUSS, MD, is organizing a trek that will accompany the 2000 Everest Environmental Expedition.

CASSANDRA FOENS, MD, has been elected president-elect to the Council of Regional Radiation Oncology Societies.

JOSE OLIVENCIA, MD, was named chair of the Ambulatory Phlebectomy Section of the American College of Phlebology.

CASS FRANKLIN, MD, was elected to the Board of Directors of the United Network of Organ Sharing.

ROGER CEILLEY, MD, was elected co-chair of the National Council on Skin Cancer Prevention.

ROBERT ROBINSON, MD, has received the Academy of Psychosomatic Medicine Annual Research Award.

DECEASED MEMBERS

JOHN BEATTIE, MD, 73, life, general surgery, Perry, October 22, 1999

HERBERT GUDE, MD, 72, emeritus, general surgery, Iowa Falls, November 22, 1999

THOMAS CORIDEN, MD, 82, life, family practice, Sioux City

EMMET MATHIASSEN, MD, 77, life, general surgery, Council Bluffs. Dr. Mathiasen was a prominent member of the Iowa medical community for decades. In 1986, he served as president of the Iowa Medical Society.

IMS welcomes NEW

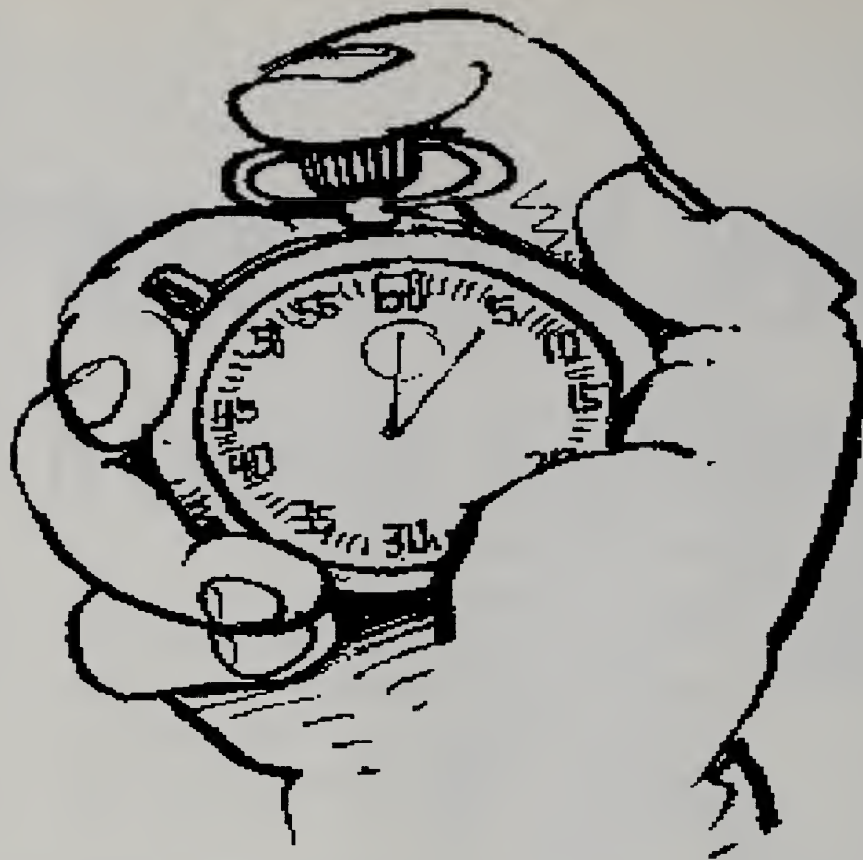
MEMBERS!

Rad Bin Tareef, MD, Dubuque
Thomas Sinsky, MD, Dubuque
David Knutson, II, MD, Cedar Rapids
Donald Johnson, MD, Cedar Rapids
Richard Stangler, MD, Cedar Rapids
Randolfo DeLeon, MD, Mason City
Jense Benjamin, MD, Hawarden
Junita Benjamin, MD, Hawarden
Jeffrey Boyd, MD, Des Moines
Kevin Crowe, MD, Des Moines

Jeffrey Sykes, MD, Sioux City
Alfred Hansen, MD, Iowa City
Matthew Rizzon, MD, Iowa City
Donald Klitgaard, MD, Harlan
Timothy Gerdis, DO, Des Moines
Diana Wright, MD, Des Moines



Members of the Iowa Medical Society join in welcoming the following new members into a progressive state medical association. The core purpose of the IMS is to assure the highest quality of health care in Iowa through our role as physician and patient advocate. Each new member is encouraged to join other IMS members at both local and state levels in achieving these goals.



Need Answers Quickly? Clock Us!!

BUSY PEOPLE need accurate information.
And they need it promptly.

That's true about data you need to help
take care of a patient or client. And it's true
also when you have a question about your
own insurance coverage needs.

At Bernie Lowe & Associates, Inc., we
answer insurance-related inquiries daily
from members of all the professional
associations we serve as sponsored
insurance administrator.

Our objective is to transmit accurate
information as quickly and thorough as
possible.

Whether it's your health insurance, your
disability insurance, your life insurance, or
other coverage, we are available by
telephone, by letter, by E-mail, by fax or by
personal visit in your office or ours.

So, put the stop watch on us! See how
rapidly we respond to your next insurance
question. We'll do our very best to be
accurate and quick.

BERNIE LOWE & ASSOCIATES, INC.
**Insurance Administrators to Professional Associations &
Universities and Colleges**
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2700 Westown Parkway, Suite 410
West Des Moines, Iowa 50266-1411

ADVICE FOR COPING WITH BME investigations



✓ *"The Board has received a complaint regarding the above captioned patient..."*

✓ *"The Board is required by law to make inquiries into all complaints..."*

✓ *"Please review this patient's records and send a written response within 20 days..."*

✓ *"In your response, please describe, in detail, your care of this patient as it relates to the allegations..."*

Your response to any of these BME inquiries, including a copy of the patient's medical records, is a critical piece in the investigation.

The key in responding is to be objective; let the medical records speak for themselves. The BME is merely seeking your recollections about the medical care you rendered.

You have 20 days to respond; take the time to draft a careful, objective and complete account of the incident. Your response to the BME complaint may dictate whether any further investi-

gation is undertaken.

Not every patient complaint is a signal that you have done something wrong. Sometimes, it just means there was a misunderstanding or a miscommunication. But whatever the cause of the complaint, ignoring it may lead to a malpractice claim or an extensive BME investigation. Facing the complaint

directly and addressing it in a timely, calm and considerate fashion will help you manage this malpractice risk.

When responding to BME inquiries

- Relate the facts of your care and treatment, expanding as needed upon what is in the record.
- Make sure you are responding to the allegations about your medical care — read carefully and jot them down, then address each briefly.
- Avoid responding defensively to emotional accusations by the patient.
- Be brief: The BME does not need excessive information.

how we learn

ESSENTIAL credentials

A recent Gallup poll confirmed a long-standing attribute of American medicine: Physicians are among the most trusted individuals in our society.

That trust has been earned by a comprehensive education providing the knowledge and skills required to prevent, diagnose and treat illness. Patients expect competence and ethical judgement from their physicians. In turn, patients literally trust their physicians with their lives.

The medical degree, specialty board certification and state licensure are the credentials that justify trust. Most physicians display these achievements with pride in their offices or clinics. These papers represent countless hours of study and clinical learning essential to the successful practice of medicine. They are requisite achievements to commence a career.

Credentials are more than "tickets." They are the foundation of the physician/patient relationship.



This column is provided by Midwest Medical Insurance Company especially for Iowa physicians. For more information, call Lori Atkinson, MMIC risk management manager, at (800) 798-9870 or (515) 223-1482.

This column is written by Dr. Richard Nelson, executive associate dean, University of Iowa College of Medicine.



dot com phenomenon

ENTICES medical field

The dot com phenomenon is leaving no stones unturned. Medical-related Web sites debut daily.

ORGAN DONATION

The National Transplant Society's National Organ Donor Registry has joined the masses. You can now register to be a donor online.

The site, www.organdonor.org, keeps a record of the donor's wish to give the gift of life in a secure database so that if tragedy does strike, organ procurement officials

can see the donor's documented intentions.

MEDICAL SUPPLY AUCTION

Are you in the need of blood plasma or syringes? Boot up your computer and surf to Pharmabid.com.

Hospitals needing medical supplies ranging from vaccines to rubber gloves can visit the site and bid on items they need. Items are sold to the highest bidder. The site could aid hospitals unable to find particular products that sometimes are in scarce supply, such as influenza vaccine

or albumin.

Buyers must prove they are licensed by the state to purchase such items.

HANDICAP ACCESSIBLE

We Media Inc. unveiled a Web site and tools to make the Internet accessible to the blind and other disabled users, www.wemedia.com.

The software will be written so the Web pages are compatible with such tools as a vibrating mouse that lets the blind "feel" boxes and images on the computer screen.

2000 OFFICES OPEN FOR ELECTION

PRESIDENT-ELECT
(1-year term)

Board of Directors
Two (2) AT-LARGE DIRECTORS
(3-year terms)

DISTRICT 2 DIRECTOR
(3-year term)

DISTRICT 3 DIRECTOR
(3-year term)

SPEAKER, HOUSE OF DELEGATES
(1-year term)

VICE SPEAKER, HOUSE OF DELEGATES
(1-year term)

AMA Delegates
Three (3)* DELEGATES
(2-year terms)

ALTERNATE DELEGATE
(2-year term)

Two (2) NOMINATING
COMMITTEE MEMBERS
(2-year terms)

house of delegates

Place your NOMINATIONS for 2000 NOW

The IMS Nominating Committee will meet Wednesday, February 9, 2000. The offices open for election are listed to the left.

*For several years, the IMS received an extra delegate to the AMA House of Delegates because at least 75 percent of IMS members were AMA members. For the last two years, this percentage has dropped below 75 percent; therefore, this extra delegate may be forfeited. As a result,

it is possible only two AMA Delegates will be elected.

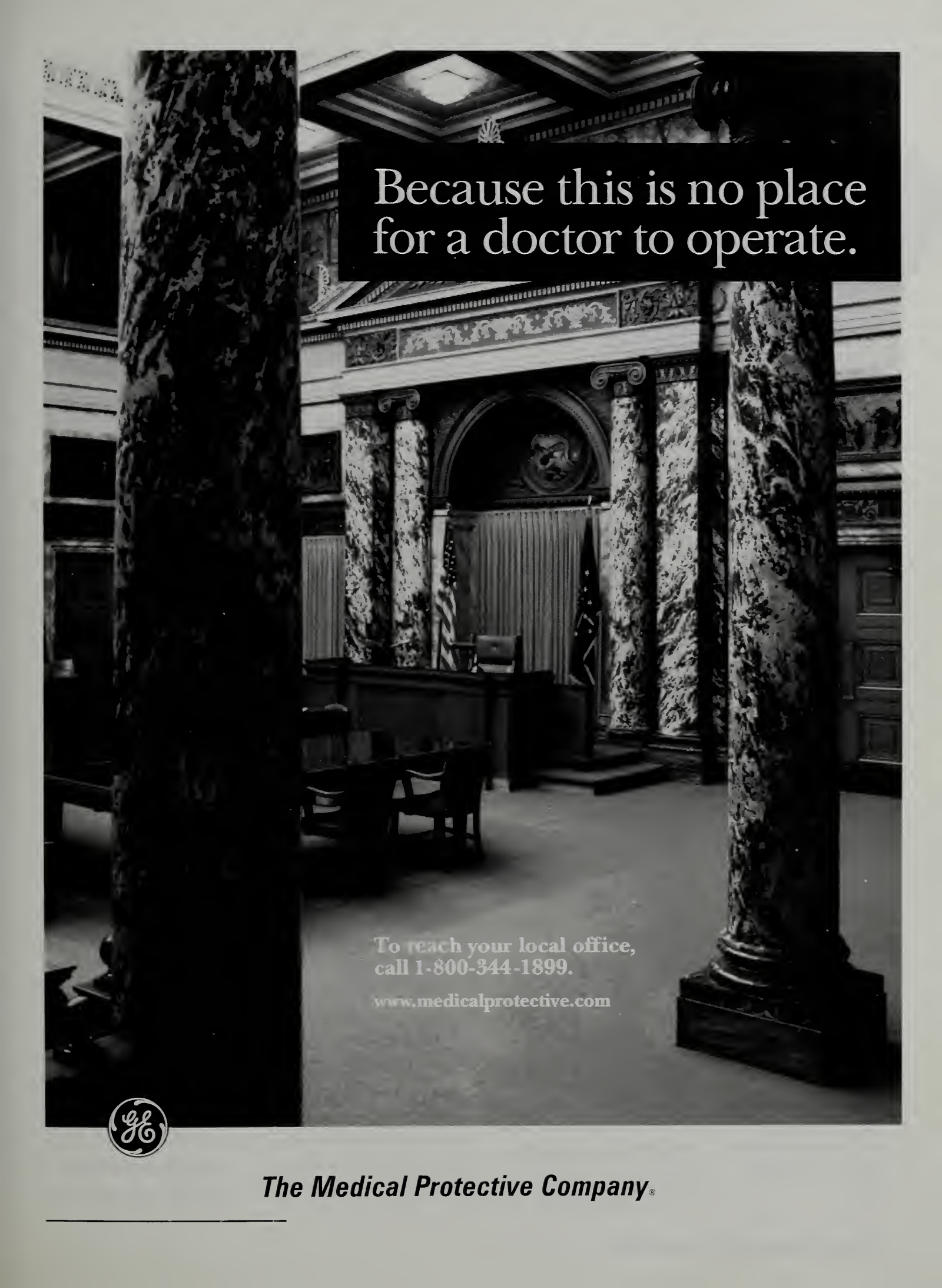
All active and resident members may run for office. In addition, members elected to life membership before April 19, 1998 may hold office. Those elected as life members after April 19, 1998, plus emeritus and stu-

dent members are not eligible.

To place nominations for any of the open positions, please contact one of the nominating committee members, or write a letter to IMS, c/o Ed Whitver, 1001 Grand Avenue, West Des Moines, IA 50265.

NOMINATING COMMITTEE

John Brinkman, MD (chair), Mason City, (515) 422-6999
Larry Baker, DO, Des Moines, (515) 263-5263
Paul Berger, MD, Sioux City, (712) 279-3955
Claudia Corwin, MD, Iowa City, (319) 356-1334
Steven Jacobs, MD, Cedar Rapids, (319) 362-3937



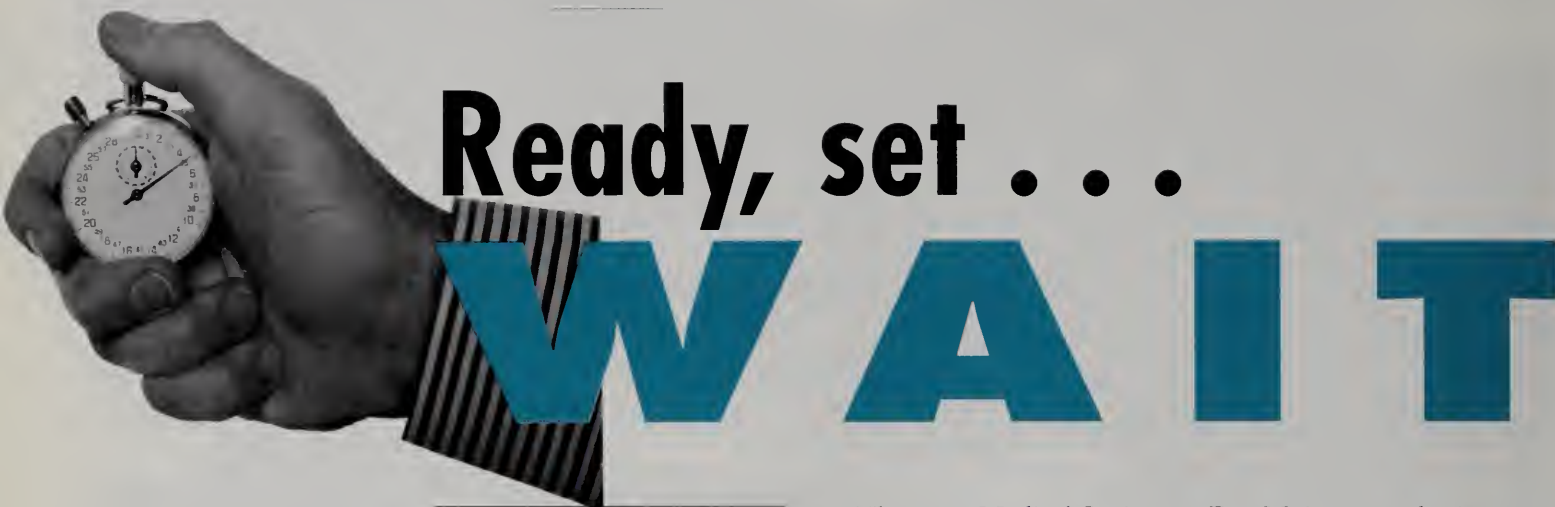
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WAIT

Complaints about how long the BME takes to process licenses have reached a crescendo.

by Chris McMahon

The new director of the Iowa Board of Medical Examiners says persistent problems in its licensing process are being addressed. Iowa physicians are wondering if increased staffing and funding requested by the BME are the answer or merely props for a disintegrating system.

A SYSTEM IN CRISIS

Complaints about the amount of time required to obtain a physician license have been a fact of life for at least the past five years in Iowa. However, during recent months complaints from physicians, clinic managers and even legislators have reached a crescendo.

The Iowa Medical Society receives numerous calls from physicians waiting to be licensed, physicians waiting for new partners to be licensed and physicians waiting for licensure renewals after the time their licenses expired. There are additional complaints about unresponsive staff, telephone calls not

More than one physician is saying the BME doggedly pursued a 'number-one-in-America' ranking in physician discipline at the expense of its other legislatively-mandated function — physician licensure.

returned and a BME telephone system overloaded with voice mail messages.

During the past year, the glacial licensing process has become an economic development issue in several Iowa communities. For example, a

Des Moines anesthesia group lost a highly trained physician who took a job in Minnesota because he got tired of waiting for an Iowa license. A radiologist recruited to Iowa City waited months for a license and was finally told by the BME that the process was held up because of a question over how long it took the physician to get an MD (he was also earning a PhD) and because the BME needed a Latin-to-English translation of his Harvard medical degree.

IMPEDIMENTS TO RECRUITING

"Physician recruitment is a competitive and costly process," says IMS Executive Vice President Michael Abrams. "A state licensure process that is sluggish and unresponsive is an unnecessary impediment to successful recruitment."

Though finger-pointing accomplishes nothing in a

This article was written by Chris McMahon, IMS vice president of communications, with contributions from Tina Stoner, publications coordinator/graphic designer.

time of crisis, plenty of people are wondering how the system got into such a mess. More than one physician is saying that the Board doggedly pursued a 'number-one-in-America' ranking in physician discipline at the expense of the its other legally-mandated function — physician licensure.

In an unprecedented show of responsiveness on the licensure issue, Ann Mowery, the new BME director, held a December 14 open hearing on the licensure process. As expected, a number of people testified. They talked about their personal experiences as clinic managers and physician recruiters trying to cope with a licensure process that can take six months or longer. On the positive side, there were many constructive suggestions on how to improve the system.

BME RESPONDS

In November, Ms. Mowery met with the IMS Board of Directors to discuss the challenges she faces as the new director of an office in chaos. She told the IMS Board the BME has been underfunded and understaffed for too long. These and a host of other factors gradually built into a crisis which is affecting a lot of people.

Ms. Mowery told IMS staff that, of the 500 new

applications received each year, at least 50 percent are incomplete when they first arrive at the BME office. Another BME staffer said the percentage of incomplete applications is even higher. However, Ms. Mowery also admits that in the past the applications have not even been opened for 60 days.

But, she has promised to change that. Her goal is that every license application currently in the BME office will be acted on by March 1. She has set a benchmark of 45 days for accomplishment of all 'first reviews' of license applications.

Ms. Mowery has also initiated a system in which the same BME staff person handles the first review, second review and follow-through for a physician.

BME staff believe a new database will allow them to cut more paper from the process and allow for quicker responses to inquiries.

INCREASED APPROPRIATIONS

In November, the Iowa Medical Society Board of Directors approved support of increased appropriations for the BME and an increase in the physician licensure fee. However, the Board made it clear that their support is based on an expected turnaround of the present situation.

Proposed licensure fee increases:

Temporary license

\$175 to \$200

Renewal of active license

\$200 to \$325

Special license

\$175 to \$200

Request for inactive licensure status

\$0 to \$325

"In the past, the IMS Board has supported BME requests for increased licensure fees. Each time, the fees increased, but there were no improvements in the process," commented Hunter Fuerste, MD, a Dubuque ophthalmologist and chair of the IMS Board. "This time, we're counting on some changes."

POSITIVE STEPS

"I believe Ann Mowery is taking positive steps to address the problems physicians have had with the licensure process," said Jeanine Freeman, vice president of public policy and advocacy for the IMS. "Ms. Mowery believes the worst is over."

Letters to doctors, the application form and a checklist have been revised to make the application process easier, Ms. Freeman said. However, she also emphasized that the IMS will continue regular contact with the BME on licensure issues.

“In the past, the IMS Board has supported BME requests for increased licensure fees. This time, we’re counting on some changes.”

IMS offers **RECOMMENDATIONS** to the **BME**

For a copy of the IMS complete testimony and recommendations, contact Cheryl Peers at the Iowa Medical Society (800) 747-3070.



The Iowa Medical Society hears regularly, sometimes daily, from clinics and physician practices regarding inordinate delays in obtaining licensure in Iowa. Even in cases where the physician's application is clean — all information has been provided, and there are no medical malpractice or disciplinary actions — final licensure can take months. Absent final licensure, the physician cannot complete the credentialing and certification processes of hospitals, government and commercial payers. Long waits for licensure affect the ability of the physician to practice, patient access to the new physician and timely processing of billing claims.

IMS RECOMMENDATIONS

1. Focus on the essential

Question the application process and eliminate items not important to assuring physician competence.

2. Know the field

Credentialing is an expertise, and the Board should not hesitate to call upon local expertise to assure its staff is knowledgeable about the best processes for timely, efficient and accurate verification of a physician's credentials.

3. Establish performance benchmarks

Set time frames for the application process to be completed.

4. Communicate with physicians

Keeping applicants in the loop, along with the hospital or clinic working with that physician, may lessen the number of phone calls to the Board.

5. Use technology

The Board is attuned to the value of computer technology, as evidenced by its Web site. The Board should take steps to effectively utilize computer technology in the licensure area as well.

6. Improve telephone and voice mail system

Physicians express high

frustration with multiple voice messaging transfers in the course of one call. We know Ann Mowery and her staff are looking at how to handle calls in a customer responsive fashion.

7. Technical changes

IMS has reviewed the Board's licensure rules and statutory law. The waiver process allowed by the Iowa Administrative Procedures Act may be an effective way to relax certain technical requirements when deemed appropriate under the circumstances at hand.

8. Establish an advisory committee

Organizations have a tendency to hold on to old ways of doing things. IMS encourages the Board to convene an ad hoc advisory committee focused on suggesting improvements to the application process. Representatives of medical practices and hospitals should be included.

Excerpted from testimony given by Michael Abrams, Iowa Medical Society executive vice president, at the December 14 hearing on physician licensure.

OSHA focuses on SAFE NEEDLE devices

A revised Occupational Safety and Health Administration (OSHA) directive issued November 5 is intended to enhance uniformity in the bloodborne pathogen inspection process. The standard reflects a stronger focus on safe needle devices and clarifies how inspectors should cite employers who fail to use effective engineering and work process controls.

NEEDLELESS DEVICES

OSHA estimates between 590,000 and 800,000 annual needlestick/sharp injuries occur in the United States. This instruction clarifies the agency's position regarding the implementation of effective engineering controls (e.g., needleless devices, shielded needle devices and plastic capillary tubes) and proper work practices (e.g., no-hands procedures in handling contaminated sharps, eliminating hand-to-hand instrument passing in the operating room) to reduce needlestick injuries.

The directive falls just short of requiring needleless

devices, but does state "The employer must review and update the exposure plan, as necessary, to reflect change in technology, such as the use of effective engineering controls, that can eliminate or minimize exposures. If the employer does not review and update its exposure control plan at least annually, the employer should be cited."

The directive further states, "Where engineering controls will reduce employee exposure either by removing, eliminating or isolating the hazard, they must be used. Significant improvements in technology are most evident in the growing market of safer medical devices that minimize, control or prevent exposure incidents."

CONTROL MEASURES

The citation guidelines for this standard state the inspector "should carefully evaluate the exposure control measures, such as effective engineering controls, in use at the facility. This evaluation should include whether other devices that are commercially available were reviewed or

considered by the employer and whether there is evidence that other engineering controls would reduce exposures. Such evidence might include Centers for Disease Control studies of efficacy, pilot tests by the employer or data available in published studies."

STUDY AVAILABLE

One such study conducted evaluates 19 devices marketed to offer protection against needlesticks. This study includes methodologies health care facilities can use to evaluate additional needlestick prevention devices and to estimate the annual increase in expenditures which will likely result when a specific device is used instead of a conventional alternative. This study can be purchased from ECRI by calling (610) 825-6000 ext. 888.

This revised OSHA directive can be downloaded at www.osha.gov.

OSHA estimates between 590,000 and 800,000 annual needlestick/sharp injuries occur in the United States.

IOWA MEDICAL SOCIETY

Don't be

*Join the Iowa Medical Society as it celebrates its
sesquicentennial Friday–Sunday, April 14–16, 2000
at the downtown Des Moines Marriott.*

hear a story of hope and courage

On May 10, 1996, a violent storm swept over Mt. Everest. Dr. Beck Weathers was among climbers severely injured. His family was notified of his death, but he awoke to find himself barely alive. "I figured I had 3 or 4 hours to live, so I started walking," he said later. He lost his right hand and part of his left hand, but he never lost hope. Come to a very special IMS Sesquicentennial luncheon Saturday, April 15 at the Des Moines Marriott and hear Beck Weathers tell the story dramatized in the book "Into Thin Air."

Special teens tell their stories

In 1997, Ryan Tripp rode his lawnmower across the country to set a world record and raised \$15,000 for a little girl in Utah who was in desperate need of a liver transplant.

the future

In 1999, Ryan promoted organ and tissue donation awareness by mowing the lawn at every state capitol.

Rashad Williams raised \$18,000 for Columbine High shooting victim Lance Kirklin who did not have health insurance, by running the Bay-to-Breakers race in San Francisco. According to his mother, her son said, "You know what Mom, that could have been me. He may be in a wheelchair the rest of his life. All I have to give him are my two legs."

Operation Smile provides funds for operations for children with facial deformities. Jennie Lillis heads up the Operation Smile Chapter at Dowling High School in West Des Moines which is raising money to help lower income families pay for cleft palate operations for their children.

it's a class

Specialties joining in the fun:

ACOG – Iowa Section
Breast and Cervical Cancer Early Detection
Iowa Academy of Family Physicians
Iowa Academy of Ophthalmology
Iowa Academy of Otolaryngology
Iowa Association of County Medical Examiners
Iowa Association of Pathologists
Iowa Orthopaedic Society
Iowa Society of Allergy, Asthma & Immunology
Iowa Society of Rehabilitation Medicine
Iowa Urological Society
Iowa Vascular Surgery Society
Neurologists of Iowa
U of I Department of Surgery

reunion affair!

Happy Birthday to us...

Happy Birthday to us...

LEFT out!

in conjunction with the
UNIVERSITY OF IOWA COLLEGE OF MEDICINE

PRICE SCHEDULE

	IMS member	Non-member physician	Student	Resident
Friday Awards Reception and Dinner — Al Haynes (Flight 232—Sioux City)	\$50	\$75	\$25	\$30
Saturday Education Session (CME and handouts included in price)	\$60	\$120	\$25	\$25
Saturday Luncheon with speaker — Dr. Beck Weathers	\$25	\$40	\$25	\$25
Saturday Reception & Dinner Dance — Dance band Freestyle	\$50	\$75	\$25	\$30

Hotel room reservations can be made by calling the downtown Des Moines Marriott at (515)

245-5500. Please request

that rooms be taken from

reservations

the block reserved by the IMS. Rooms have also been reserved at the Hotel Fort Des Moines (515) 243-1161 and the Savery Hotel (515) 244-2151. A rate of \$89 has been arranged for physicians attending this meeting.

IOWA MEDICAL SOCIETY SESQUICENTENNIAL

1850-2000
150 Years
OF CARING FOR IOWANS

Why wait? Register TODAY!

Two ways to register: **1. Fax...** to the Iowa Medical Society at (515) 223-8420 *Faxed registrations will not be accepted without credit card information.*

2. Mail... to the Iowa Medical Society, Attn: Becky Bales, 1001 Grand Avenue, West Des Moines, IA 50265.

Name _____

Academic degree _____ Medical specialty _____

Social Security number for CME purposes _____

Office/clinic _____

Street address _____

City _____ State _____ Zip code _____

Telephone _____ Fax _____

Email address _____

Are you a ☐ IMS member ☐ Non-member physician ☐ Resident ☐ Student ?

Please check the events you plan to attend and how many tickets you are purchasing.

- ☐ _____ Friday Awards Reception and Dinner with speaker Al Haynes (Flight 232—Sioux City)
☐ _____ Saturday Education Session (CME and handouts included in price)
☐ _____ Saturday Luncheon with speaker Dr. Beck Weathers (Mt. Everest climber/survivor)
☐ _____ Saturday Reception & 150th Birthday Party/Dinner Dance (Dance band Freestyle)

Payment Options

☐ Check in the amount of \$ _____ payable to Iowa Medical Society

☐ Credit card (circle one)
MasterCard VISA

Credit card number _____

Cardholder name _____

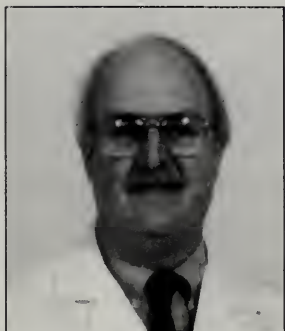
Signature _____

Expiration date _____

Amount charged _____

ACCESSIBILITY CHECKLIST FOR MEDICAL OFFICES

- ❑ Designated handicapped parking spaces should be at least 96 inches wide.
- ❑ Check your flooring. Does your office have a high pile carpet making it difficult for a person who uses a wheelchair to get around?
- ❑ Check your entrance door handles. Can someone with limited hand-use open the door?
- ❑ Can someone in a wheelchair be seen at your registration desk? Can that person sign in?



Excerpted from "Disability Awareness — A Primer for Physicians" by Roger Ceiley, MD; Sandra Gordon, MA; and Rebecca Gordon, BS. Copies of the report are available through the Iowa Medical Society. Contact Becky Bales, coordinator of communication and medical education services at (800) 747-3070.

Is your office handicap COMPLIANT?

People with disabilities continue to face a significant number of impediments when trying to obtain adequate health care.

Gerben DeJong, PhD, director of the National Rehabilitation Hospital Research Center in Washington, DC, points out that "People with disabilities are high users of health services." DeJong describes six general ways in which ongoing health care needs of people with disabilities differ from those of the general population:

1. People with disabilities generally have a thinner margin of health that must be carefully guarded if medical problems are to be averted.
2. People with disabilities often do not have the same opportunities for health maintenance and preventive health.
3. They may experience an earlier onset of chronic health conditions.
4. They may have great susceptibility to secondary functional losses.
5. There may be a complicated and prolonged treatment for a health problem.
6. The need for durable medical equipment and other

assistive techniques that require some level of functional assessment.

As our population grows and ages, an increasing number of your patients will use wheelchairs or develop vision

or hearing impairments. Making changes in your office to accommodate these patients is not just the law; it is good business and it is compassionate patient care.

SCIENCE, not politics should direct use of TOBACCO MONEY

Iowa's war on tobacco should be based on science not on politics, say Iowa physicians weighing in on the question of how Iowa's share of the tobacco settlement should be spent.

"Iowa's share of the tobacco settlement should be spent on aggressive anti-smoking programs for children and on programs to help smokers quit," says Siroos Shirazi, MD, president of the Iowa Medical Society.

A subgroup of the Iowa Medical Society's Public Health Committee studied the question of how tobacco dollars should be spent and made recommendations based on the practical experience of Iowa physicians and on recommendations of the Centers for Disease Control.

"Physicians see first-hand the effect of tobacco on the nearly 25 percent of Iowans who continue to smoke," explains Charles Helms, MD, a University of Iowa internal medicine specialist who headed the tobacco subgroup. "This puts us in a position to make recommendations that are based on clinical evidence."

Iowa's share of the tobacco settlement will be \$1.7 billion over a period of 25 years.

"We have a chance to use this money to keep our youth from smoking and help Iowans who already smoke. It would be wrong to allow political and budgetary considerations to undermine this goal," Dr. Helms concludes.

AMA launches National House Call

Citing unfinished Patients' Bill of Rights legislation, 44 million Americans without health insurance and a Medicare system badly in need of reform, the American Medical Association (AMA) launched an initiative to ensure the next president puts health care at the top of his policy agenda.

AMA leaders will join with state and local medical association leaders on a "National House Call" tour of key primary states to raise the visibility of health policy

issues. This is a more activist role for the AMA in a presidential campaign.

"The AMA strongly believes that no candidate can be elected next November without a solid commitment to addressing those critical health care issues that mean the most to patients, physicians and the well-being of families nationwide," said Thomas Reardon, MD, AMA president.

"The AMA has looked at managed care patient restrictions, the lack of health

insurance for so many Americans and a host of other current U.S. health policy problems," said Dr. Reardon. "In each case, we have asked a basic question, 'Is it good medicine?'"

Dr. Reardon and officers of the Iowa Medical Society were on hand December 13 at the Republican debate in Des Moines to raise these issues with voters and candidates.



reimbursement

AMA files *LAWSUIT* against HHS Sec. Shalala

The American Medical Association (AMA) filed a lawsuit in federal court on Thursday, December 2, 1999, charging Health and Human Services (HHS) Secretary Donna Shalala with acting contrary to the intent of Congress by refusing to exercise her authority to correct errors in the system used by Medicare to pay physicians for care provided to the nation's elderly.

The AMA maintains that HCFA had the statutory authority to implement annual reconciliations for

shortfalls created by erroneous projections in the Sustainable Growth Rate (SGR) of Medicare spending. HCFA promised the difference between its projections and actual data would be corrected in future years, but it reneged on this promise a year later. Failure to correct the projection errors has resulted in an unlawful fiscal burden for physicians estimated at \$3 billion.

If successful, the lawsuit would require HCFA to compensate physicians for the undercalculation that

took place in 1998 and 1999 by adjusting the annual update of payments for physician services under Medicare.

SUSTAINABLE GROWTH RATE — HCFA'S GROSS UNFAIRNESS TO PHYSICIANS

- The SRG is used to control Medicare spending for physician services by measuring
 - ✓ Changes in spending due to fee increases
 - ✓ Movement of beneficiaries from fee-for-service to managed care
 - ✓ Overall economy as measured by the gross domestic product
- HCFA uses projections in place of actual values
- AMA estimates "unlawful" SRG calculations have resulted in a \$3 billion loss to physicians
- Iowa's total loss is \$30.3 million. Loss per physician is \$3,886.

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Don't **JUMP** the gun...



Media hype may not be a reason to change your investments.

by Jerry Foster

The unprecedented power and duration of this bull market has given birth to a rash of unhealthy expectations for long-term returns on portfolios. After all, why not load up on tech stocks and get a stellar return of 50 percent or better?

If that seems a bit too risky, then why not buy the Standard & Poor's (S&P) 500 and cruise along with a reasonable 25 percent?

If you are making your investment decisions based on information provided by the media covering the gyrations of the highest priced stocks, it is very easy to get caught up in this manic kind of hype. This spellbinding

ascent of today's high-flying stocks has caused many investors to think short-term while losing sight of the longer term objectives for which they are saving.

It is important to understand when hearing of these outstanding returns that just 10 stocks accounted for 43 percent of the S&P 500's gain last year; 25 stocks for 67 percent, and 33 stocks for over 75 percent. Miss those 33, and suddenly the S&P does not look so hot. A long-term look at the S&P shows a return of about 11 percent per year. When planning for long-term needs such as retirement, an 11 percent return would make most people very satisfied.

When looking at your long-term goals, you will probably conclude those goals differ from the fast-moving marketplace which those higher returns are coming. The key to a successful investment and financial planning experience is to

focus on your portfolio's "required"

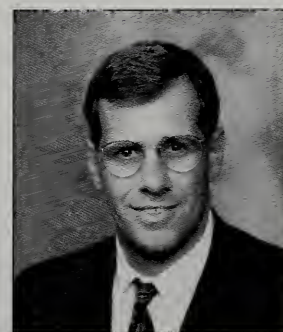
rate of return. In other words, what do you need the portfolio to return in order to meet your financial objectives? Important questions should be considered to

establish that required return. When do you anticipate retiring; what is your life expectancy; what other income sources do you anticipate; and what will your expenses be?

Focus your overall investment strategy in the context of your personal goals, not on making as much money as possible in as short a time as possible. If you keep that focus, you will avoid the pitfalls of chasing high returns.

IMPORTANT QUESTIONS TO ASK BEFORE JUMPING TO CHANGE INVESTMENTS

- ✓ **When do you anticipate retiring?**
- ✓ **What is your life expectancy?**
- ✓ **What other income sources do you anticipate?**
- ✓ **What will your expenses be?**



Jerry Foster is the CEO of Foster Capital Management, a fee-only financial planning and investment management company located at IMS headquarters, (800) 798-1012.

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IMSA long term care forum a **SUCCESS**

In planning an educational forum on long term care, the Iowa Medical Society Alliance (IMSA) never dreamed it would gather 150 people, including local legislators.

"The Many Faces of Long Term Care" was presented in Waterloo on November 4, 1999. The forum was sponsored by the Long Term Care Task Force (LTCTF), a group of organizations interested in long term care brought together by the IMSA (*see box*).

The forum included a general session and a choice of two informative breakout sessions. The sessions, presented by local and statewide

experts, were Financial Challenges and Confusion; Choosing a Nursing Home Facility; Long Term Care Caucus Project and Alternatives to Nursing Homes.

The evening was a huge success. Attendance was better than anticipated, and the only complaint we received was it should have been longer.

We hope to do more in the future to continue educating Iowans on this crucial issue. State Alliance members involved in this forum

Long Term Care Task Force

American Association of Retired Persons
Advocacy Network for Aging Iowans
Aging Resources, Area XI, AAA
Black Hawk County Medical Society Alliance
Citizens for Long Term Care
Employees and Family Resources
Hawkeye Valley Area on Aging
Iowa Caregivers Association
Iowa Medical Society Alliance
Iowans for Nursing Home Reform
Office of the State Long Term Care Ombudsman
Long Term Care Campaign Caucus
Quality Care Advocates of Black Hawk County

include Tess Young, co-chair; Ann Crouch; Barb Savage and Barbara Bell. This was truly a project to bring pride to the IMSA.

We were proud to represent our medical spouses in such a positive way.

AMA Foundation Holiday Thank You! sharing card Contributors

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Sarah Kabliska	Tess Young



*This article was written by
Gail Sands, IMSA
president*

next month

FOCUS on IMS HISTORY

In June of 1850, the Iowa State Medical and Chirurgical Society was formed by Dr. John Sanford in Burlington. In April of 2000, the Iowa Medical Society is celebrating its 150th birthday. Next month's *Iowa Medicine* will focus on the rich (and sometimes colorful!) history of the IMS and Iowa

physicians. The cover will feature a limited edition print commissioned in honor of the IMS Sesquicentennial. Read about a history of Iowa

medicine currently being written as a cooperative effort of the IMS and the University of Iowa College of Medicine. Learn about the display on the history of

Iowa medicine which will make the rounds of Iowa hospitals all during this year.

Don't miss this special issue.

IOWA MEDICAL SOCIETY SESQUICENTENNIAL
150 Years 1850-2000
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In search of Iowa medical journals—The University of Iowa Library is searching for copies of *Iowa Medicine*, *Journal for the Iowa Medical Society* from 1853-68. If you have a set of these and would be willing to donate them to the state library or the UI library system, please contact Susan Lawrence at LawrenceS@mail.medicine.uiowa.edu. It would be great to have a set of these available for public research.

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"The Iowa Medical Society has proven a great resource for educating physicians and patients about public health concerns."

Julius Conner, MD

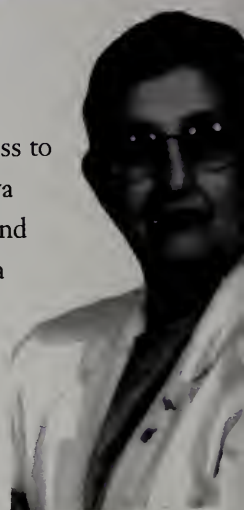
IMS seeks opportunities to educate physicians and patients about public health concerns. Your membership dues this year have helped pay for a new video that will train mandatory reporters to recognize the signs of dependent adult and child abuse. Physician contributions to the IMS Education Fund helped support the distribution of 7,500 domestic abuse victim education and intervention booklets.

"The Iowa Medical Society brings into focus important public health issues such as consumer access to medical care and quality of care in managed care contracts. IMS also promotes important legislative actions which will impact the health of Iowans."

Rizwan Shah, MD

Concern for public health extends to ensuring that Iowans have access to quality medical care. Before managed care products even hit the Iowa marketplace, the IMS worked with other health care organizations and Iowa insurance companies to create the "Principles of Agreement," a document which protects the rights of patients as well as physicians under managed care. Last year, patients also received the right to choose their physicians thanks to a point-of-service law proposed and supported by the IMS. The new IMS Committee on Public Health takes advantage of the partnership of IMS members to further support public health advocacy activities.

*Julius Conner, MD
Polk County Department
of Public Health
Des Moines*



*Rizwan Shah, MD
Peoria
Blank Children's
Des Moines*

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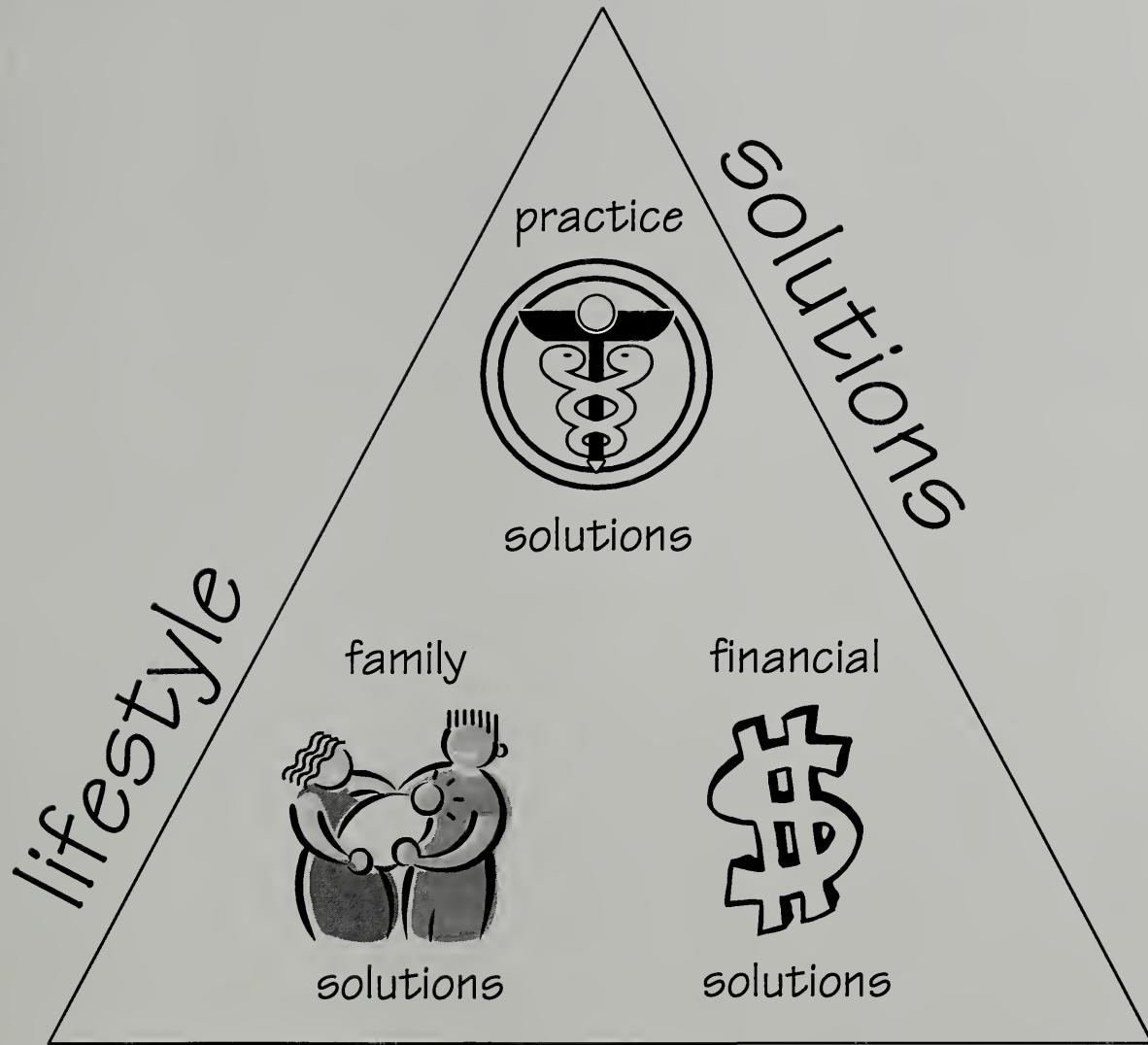
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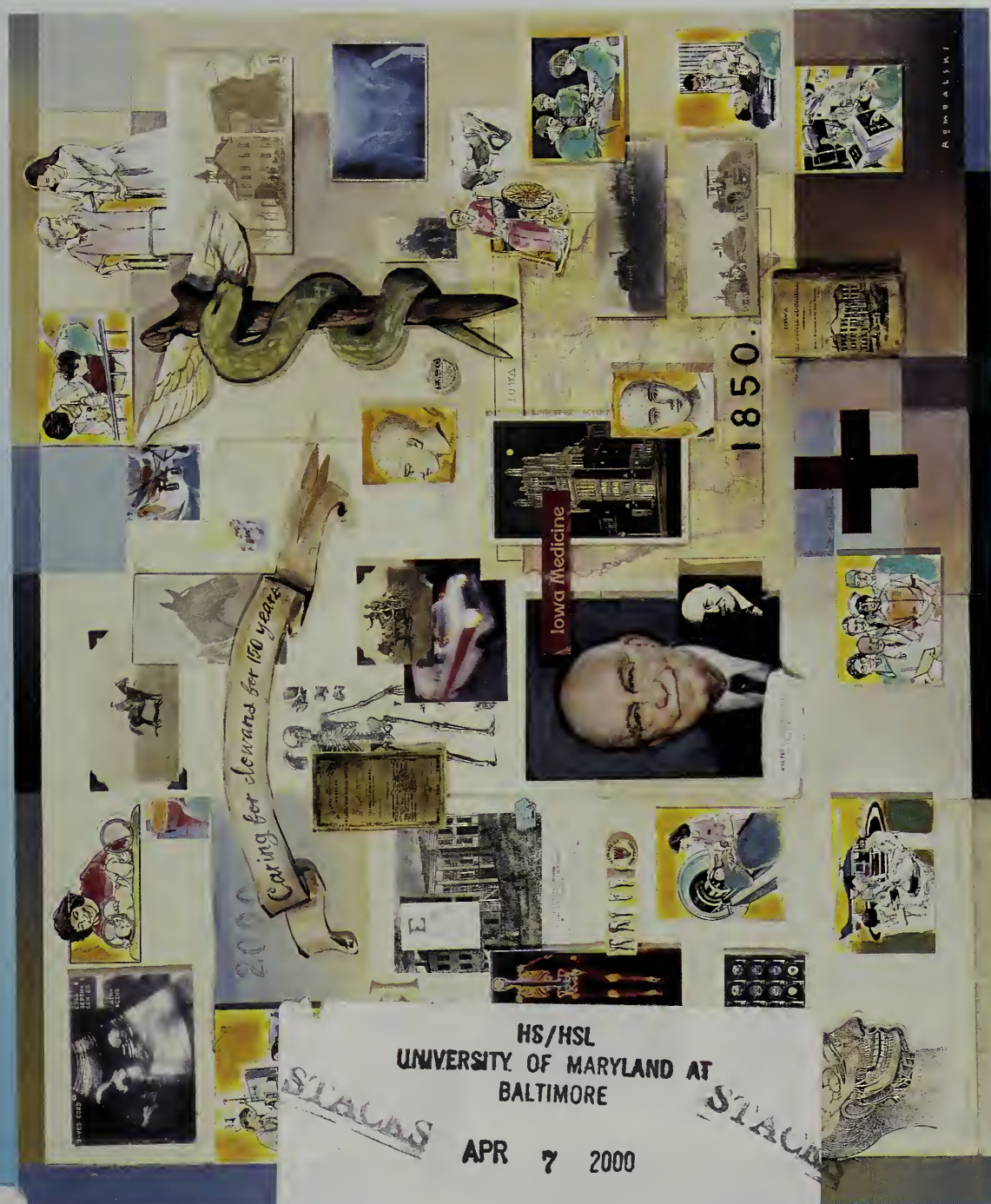
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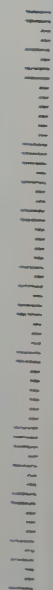
Iowa Medicine

March/April 2000 An Iowa Medical Society publication



Don't miss the excerpt from a new book on the history of medical practice in Iowa — page 10

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Governor Vilsack
— page 4

Old law, new bite
— Mandatory
abuse training
— page 15

Texas physician from
"Into Thin Air" at IMS
Annual Meeting
— page 18

Assignment of benefits
bill is a priority for
IMS — page 29

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IowaMedicine

Published by the Iowa Medical Society

March/April 2000

Vol. 90/2

Special commemorative edition of *Iowa Medicine*!

IOWA MEDICAL SOCIETY SESQUICENTENNIAL
150 Years 1850-2000
OF CARING FOR IOWANS

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Improving the health care of all Iowans tops list of Governor's goals.

15 legalities

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6 150th celebration year-long events

The IMS 150th Committee wanted to give something back to Iowans.

24 house of delegates

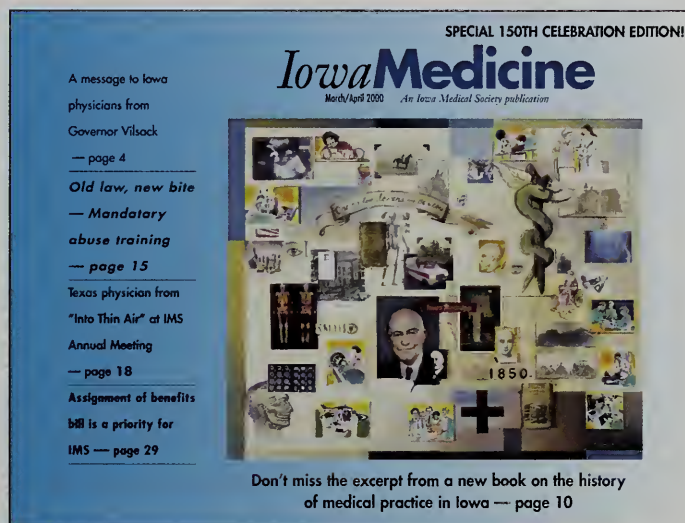
Candidates for 2000 IMS offices announced.

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Would you believe IMS is monitoring over 300 bills in the Iowa Legislature?



This month's feature:

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REGULARS

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High-quality, **AFFORDABLE HEALTH CARE**

Improving health care services in Iowa will, in turn, improve the health of all Iowans.

by Governor Tom Vilsack

Iowa has an unprecedented opportunity to use the tobacco settlement dollars to improve and enhance the health of all Iowans. If invested wisely, these funds will make Iowa a national leader in health care by creating a comprehensive health care system that may pay for itself over time through savings of reduced health care costs.

One of mine and Lt. Governor Sally Pederson's goals is to make sure all Iowans receive affordable, high-quality health care. We want to make sure Iowa, whose population has declined and aged at an alarming rate, has the resources to compete in the

global economy of the new millennium. That means providing initiatives that take us toward our goal of more Iowans, younger Iowans and better-paid Iowans.

To help reach that goal, we want to seize the unparalleled opportunity Iowa has from the millions of dollars provided by the tobacco settlement. Last January, we unveiled a plan to use the tobacco settlement money to create a comprehensive health care system focused on the prevention of illness and disease. From ensuring all kids have access to health care to making sure our seniors have adequate care, our health care package truly prioritizes the needs of Iowa's working families.

Our plan also uses innovation to draw down more than

Governor Vilsack & Lt. Governor Sally Pederson's Health Care Goals for Iowa

- Expanding HAWK-I to insure thousands of additional children in low-income or impoverished families
- Investing money to make more low-income children eligible for Medicaid on a 12-month, rather than current month-by-month, basis
- Creating a comprehensive tobacco program for children and adults that is focused on education, cessation and treatment
- Creating an innovative and balanced long-term care system, funded through federal dollars, that allows seniors to receive the alternative services they want.
- Providing services to children with special needs, including respite care for families
- Expanding community-based substance abuse treatment and prevention programs across the state

\$138 million in federal funds.

This is just a start. By making these health investments now, we can improve current health care services available to the most vulnerable Iowans and make progress in prevention that will improve the health of all Iowans for decades to come.



Governor Vilsack strongly supports legislation that will ensure high quality health care for all Iowans.

\$600,000

raised for IMS Endowment Fund

Dr. Shirazi bids farewell after an extremely productive year as IMS President.

by Siroos Shirazi, MD

When I began my term as president, I set three specific goals:

1. To meet as many Iowa physicians as possible;
2. To communicate the strength of the Iowa Medical Society advocacy department and to reiterate how they advocate for you and your patients; and
3. To establish an endowment fund for future generation of Iowa physicians.

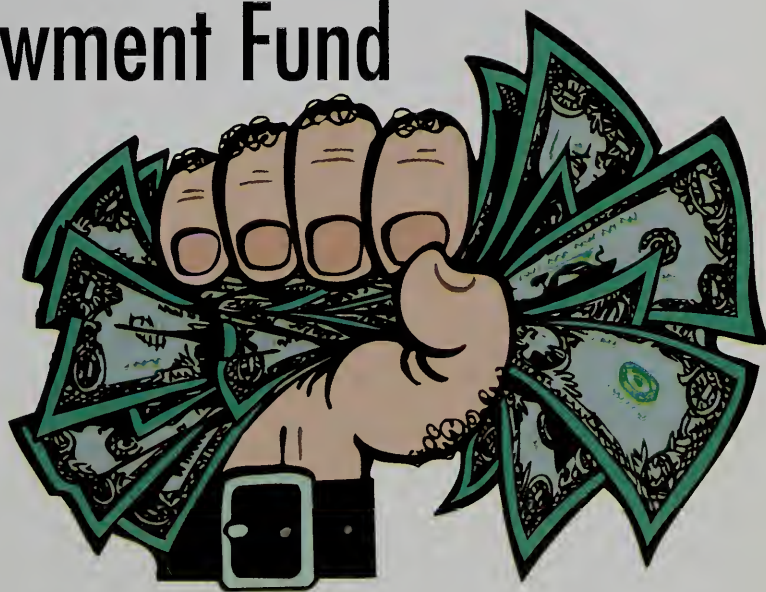
Through our travels across Iowa, Mike Abrams and I met with small and large groups. I was inspired by your insight, your compassion for your patients and your concern for the direc-

tion that medical practice is taking us. I hope everyone we met is assured that the Iowa Medical Society advocacy team is second to none.

I have positive news about our education endowment campaign, even though we have not achieved our goal. The endowment fund has \$600,000 in new pledges, and I hope to greatly increase this amount as the fund raising campaign continues next year.

I am asking each practicing Iowa physician to contribute \$1000. I will continue to pursue this goal to assure any bright Iowa graduate does not have to think twice about going to medical school due to the thought of hundreds of thousands of dollars of debt.

The reason for this endowment is to give Iowa high school graduates a reason to stay in Iowa. We do not want our brightest choosing to go to out-of-state medical schools, because they receive



a better financial package.

I think we can afford \$3 a day for a year or \$2 a day for 18 months or \$1 a day for three years in order to have this important endowment established. Such a small individual sacrifice could result in a large and incredible endowment, which would potentially send 30 Iowa graduates to medical school with full scholarships.

On a side note, my call to our female members resulted in very positive response. I am glad to report we have the benefit of their leadership in every standing committee of our society, and I am assured this will be a norm rather than exception in the future.



Dr. Shirazi is a general surgeon at the University of Iowa Hospitals and Clinics and president of the Iowa Medical Society.

year-long events

IMS celebrates 150 years of caring

1850-2000

Celebrating 150 years
of caring for Iowa
patients cannot happen
in just one weekend!

- Monograph that celebrates the practice of medicine by Iowa physicians and scientists
- Limited edition prints developed by a local artist
- 'Family of Medicine' education session for IMS and

specialty societies at the IMS Annual Meeting April 14-16, plus dinner, dancing and an inspirational presentation during Saturday's luncheon by Dr. Beck Weathers.

SUPPORT THE IMS Sesquicentennial!

From the time of its founding in 1850, the Iowa Medical Society has had a strong tradition of serving physicians who care for Iowans. The IMS is working with the University of Iowa College of Medicine to develop projects to celebrate "150 years of caring for Iowans" in 2000.

- Mini medical schools in nine Iowa communities
- A traveling exhibit for Iowa hospitals on the history of physicians and medicine in Iowa
- Educational school assemblies



Dr. Laaveg is the chair of the IMS Sesquicentennial Committee. He is an orthopaedic surgeon in Mason City and president-elect of the Iowa Medical Society.



Contribute today!

When you contribute \$250, you will receive a limited edition, matted print, signed by the artist. By contributing \$150, you will receive a limited edition, high-quality paper print, signed by the artist. Or you can purchase a poster for \$35.

Call the Iowa Medical Society for an order form! Prints will also be available at the 2000 IMS Annual Meeting at the downtown Des Moines Marriott, April 14-16, 2000.

WATCH for the IMS Traveling Exhibit



Iowa Hospitals and Clinics Medical Museum.

In 1850, there was very little in a doctor's armamentarium. Anesthesia had just been discovered but was not in general use. The germ theory of disease had

been proposed but would not be generally accepted for another 50 years. Antibiotics were 100 years away.

So what did physicians have to work with? There was alcohol, opium to relieve

pain, leeches, cupping, scarificators and fleams for blood-letting. Herbs and other plants were widely used to treat conditions such as malaria.

Viewers of the exhibit will learn about the origins and practice of medicine in 19th century Iowa. Maps and early photographs of doctors, patients and doctors-in-training give a sense of what Iowans may have experienced 150 years ago. Scenes from Oakdale Sanatorium (a facility that treated patients with tuberculosis) plus descriptions of five mental health facilities in Iowa tell the story of patient care in an earlier day.

To us, the scenes may seem primitive but at the time, this care was thoroughly modern. In another 100 years, our technologies will seem equally antiquated.

Don't see your hospital listed to the right? There's still time and space to reserve the exhibit! Call your hospital today and tell them you want to see the exhibit in your town. Your hospital contact person can call the Iowa Medical Society at (800) 747-3070 and ask to reserve a spot!

The Iowa Medical Society, on the occasion of its sesquicentennial, is pleased to present an exhibit on the history of medicine in Iowa. The exhibit was prepared by the University of

Spotlighting PATIENT needs

In planning the events to celebrate the Iowa Medical Society's 150th Birthday, the IMS Sesquicentennial Committee felt Iowa physicians should give something back to their patients.

Mini-medical school programs will be held in Mason City, Ames, Burlington, Dubuque, Davenport, Waterloo-Cedar Falls, Council Bluffs, Des Moines and Sioux City.

These programs are designed to familiarize the lay public with biomedical research and the latest in medical treatments. More than just a scientific lecture, presentations include colorful analogies and humor to make complex information understandable.

Programs will be free, open to the public and appeals to young adults (age 17+) as well as older members of the community.

Watch the above communities for more information!

coming to a town near you...

March 17, 2000

- ✓ Hancock County Memorial Hospital — Britt
- ✓ Floyd Valley Hospital — Mars

April 11, 2000

- ✓ Buena Vista County Hospital — Storm Lake
- ✓ Iowa Medical Society — West Des Moines

April 18, 2000

- ✓ Unity Health System — Muscatine

May 1, 2000

- ✓ Greene County Medical Center — Jefferson
- ✓ Spencer Municipal Hospital — Spencer

May 17, 2000

- ✓ Central Community Hospital — Elkader
- ✓ Keokuk Area Hospital — Keokuk

June 2, 2000

- ✓ Ottumwa Regional Health Center — Ottumwa
- ✓ Mercy Medical Center-North Iowa — Mason City

June 19, 2000

- ✓ St. Luke's Hospital — Cedar Rapids
- ✓ Genesis Medical Center — Davenport

July 7, 2000

- ✓ Burlington Medical Center — Burlington
- ✓ Palmer Lutheran Health Center, Inc. — West Union

August 1, 2000

- ✓ Baum-Harmon Memorial Hospital — Primgha
- ✓ Wayne County Public Hospital — Corydon

August 21, 2000

- ✓ Ringgold County Hospital — Mount Ayr
- ✓ Waverly Municipal Hospital — Waverly

September 8, 2000

- ✓ Dallas County Health System — Perry
- ✓ Cass County Memorial Hospital — Atlantic

September 26, 2000

- ✓ University of Iowa — Iowa City

October 2, 2000

- ✓ Mercy Medical Center-Cedar Rapids — Cedar Rapids

October 16, 2000

- ✓ Grinnell Regional Hospital — Grinnell

November 1, 2000

- ✓ Kossuth Regional Health Center — Algona

November 3, 2000

- ✓ Lucas County Health Center — Chariton

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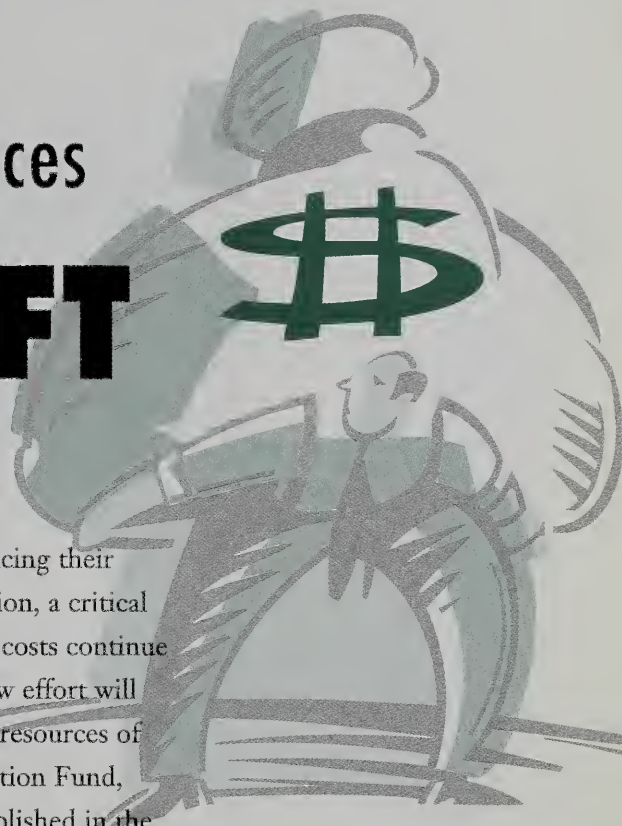
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It's called finding common ground. Then, giving it value. And it benefits all by securing the dignity, integrity and financial security of your profession as healthcare providers. Talk to us. Both of you. We'll listen. Then, we'll provide a customized coverage plan that supports your needs. Contact your agent or call PIC Wisconsin at 800-279-8331 or e-mail info@picwis.com, and put us in your shoes.

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Turning Common Ground Into Uncommon Solutions



IMS Educational Campaign announces **STRATEGIC GIFT**



The Executive Committee of the Iowa Medical Society has announced an IMS commitment of \$250,000 to the IMS Legacy Endowment Fund Campaign. The purpose of the fund is to assist deserving Iowans in covering the tuition cost of their medical education and support health promotion activities around the state.

Including the IMS gift, physicians have contributed some \$309,000 to the campaign, which seeks to raise a three-year goal of \$3 million. It is the organization's first effort to fund an endowment.

Siroos Shirazi, MD, IMS

president, defined the campaign vision in April of 1999 at the time he took office. A focal point of his activity as president has been to make personal contact with as many Iowa physicians as possible, asking each to contribute \$1,000 as an investment in the future of Iowa medicine.

Contributions and pledges now exceed \$593,000. Iowa employers, including health care-related organizations are also being asked to contribute to the initiative. Gifts are fully tax-deductible.

Dr. Shirazi's idea is a timely extension of the IMS's long-standing commitment to providing assistance to

Iowans in financing their medical education, a critical need as tuition costs continue to rise. The new effort will strengthen the resources of the IMS Education Fund, which was established in the early 1950s to fund low-interest medical school loans and public health promotion activities.

"In honor of the Society's Sesquicentennial anniversary, we intend that this new fund will establish a legacy of giving that will stand for the next 150 years," said Shirazi.

Contact Dr. Shirazi at (319) 356-2006 or Deb Potter at the IMS, (800) 747-3070 or (515) 223-1401.

Use the Business
Reply Envelope
tucked inside this
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Iowa Medicine
to mail in your
contribution!

The IMS Legacy Endowment Campaign **APPRECIATES** your generous support.

- ☐ My contribution is enclosed. I understand that my contribution is fully tax-deductible.
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- ☐ Please send information on planned giving opportunities.
- ☐ I am interested in serving as a campaign volunteer.

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CREDIT CARD NUMBER EXPIRATION DATE CARDHOLDER SIGNATURE

- ☐ My employer will match my gift (Please mail me the required employer form.)

New book chronicles history of

MEDICINE in Iowa

Relive Iowa medicine history through a monograph celebrating the IMS Sesquicentennial.

by Richard Nelson, MD and Susan Lawrence, PhD

Over the last century and a half, medical knowledge and practice have undergone extraordinary changes. The history of medicine in Iowa is a local story, as well as a story of Western medicine as it unfolded in the United States. Iowa physicians worked to organize a modern profession, to treat their patients according to the accepted principles and therapies of their days and to contribute new knowledge and techniques to the expanding amount of medical information available to researchers and practitioners.

The Iowa Medical Society,

in conjunction with the University of Iowa College of Medicine, has developed a monograph that explores the practice of medicine by Iowa physicians and scientists to celebrate the Iowa Medical Society Sesquicentennial.

The monograph is divided into two sections: Iowa medicine from 1850-1950 and Iowa medicine from 1950 into the future.

IOWA MEDICINE 1850-1950

In the 1860s and 1870s, Iowa physicians faced the hardships of pioneer life along with the morbidity and mortality brought by the epidemics and infections that threatened all of our ancestors, whether rural or urban.

In the 1910s and 1920s, x-ray machines, blood tests and new laboratory-produced therapies challenged the skills and pockets of relatively isolated physicians and their patients.

In the 1930s and 1940s, economic depression and

World War II drove home the meaning of unaffordable health care and then ushered in an entirely new level of government funding for scientific research and technological development.

From 1850 to 1950, a few particular events, issues or cases showcased the tensions as well as the harmonies among physicians. Not all changes were equally welcomed, by any means; nor can all of the fascinating stories be told.

1950 TO THE FUTURE

The development of the institutional infrastructure required for biomedical and clinical research, and the consequent concentration of such work at the University of Iowa in its system of laboratories and hospitals was an important progress point in Iowa medicine.

Given the considerable number and complexity of significant research results produced in Iowa, it is

IMS 150TH MONOGRAPH SENIOR PHYSICIAN WORK GROUP

Richard Nelson, MD
Marion Alberts, MD
Clarence Denser, Jr., MD
Russell Gerard, II, MD
Louis Greco, MD
John MacGregor, MD
Hormoz Rassek, MD
George Spellman, MD
Chris McMahon
Mary Jo Young

impossible to cover them all. However, numerous examples illustrate the range and diversity of the contributions Iowans have made to medical knowledge. These include the neuropsychological basis of learning disabilities, the understanding of human locomotion, the effects of environmental toxins and the preservation of human blood for transfusion.

Many issues surround the delivery of health care to people living in large cities, small towns and on the widely separated farms that characterize Iowa's landscape in the 20th century. After 1900, procedures and care for the severely sick gradually moved into hospitals, while even the ill and injured who did not need hospitalization increasingly had to travel to x-ray machines and laboratory facilities for diagnosis and treatment.

Iowa has led the nation in pioneering perinatal care and emergency medical transport programs. The University of Iowa College of Medicine also had a vital role in developing family practice as a specialty, with the considerable support for residency programs around the state,

after the traditional general practitioner disappeared in the post-war era.

Rapid changes in medical technology, pharmaceuticals and complex operations like

effectively distributed around the state. The cost of health care and the tensions produced by competition among providers for patients and funds, have shaped and will

continue to influence the directions the profession and business of medicine take in Iowa well into the 21st century. Among the issues highlighted are

IMS 150TH MONOGRAPH CHAPTERS

1. 1833-1886 — Settlement and Identity
2. Towards the Research Ethic, 1887-1928
3. Depression, War and Transformation of Scientific Medicine, 1929-1950
4. The Contributions of Iowans to the Advancement of Biomedical Science and Practice
5. The Evolution of Contemporary Medical Practice in a Rural State
6. Speculations on the Future of Medicine



organ transplants have required practitioners, hospital administrators, insurance companies and city, county and state officials to discuss regularly how facilities and other resources can be most

the on-going concerns of environmental contaminants on the health of Iowans and the provision of community mental health services for the homeless and under-insured.

IOWA MEDICAL SOCIETY SESQUICENTENNIAL MONOGRAPH

BACKGROUND — The volume marks the sesquicentennial anniversary of the Iowa Medical Society and will be published in 2001. Planning for the book started well over a year ago, and the writing is well underway. The authors have faced challenges as the work has developed, from difficulties in tracking down information to struggles over what to include and what to leave out.

AUTHORS — Richard Nelson, MD, professor of pediatrics and executive associate dean and Susan C. Lawrence, Ph.D, associate professor of history and member of the Program in Biomedical Ethics and Medical Humanities, both from the UI College of Medicine are the two main authors of the monograph focusing on the history of medicine in Iowa.

Richard Caplan, MD, emeritus professor of dermatology; founder of the program in Medical Humanities, is contributing his personal reflections on Iowa medicine as well.

WHERE AND WHEN TO GET YOUR COPY — You can reserve your copy at the 2000 IMS Annual Meeting. There will be a booth in the exhibit hall with reservation forms. Books will be available after publication in 2001.

The Evolution of Medical Practice in a Rural State

Excerpted from Chapter 5

"...The majority of professionals in the 19th century on the frontier functioned as individuals. Physicians were no exception. They established an office, commonly in their homes and examined and treated patients within that setting. Due to the generic nature of medical training, most physicians practiced the full gamut of medicine and surgery possible at that time. Commercially prepared medications and treatments, or a variety of powders, ointments and liquids prepared by the physician were prescribed. Minor surgeries and other manipulations were performed in the office. In communities with more than a single physician, independent practice was still the norm. Physicians did not necessarily compete in that circumstance, nor were they particularly cooperative in their efforts. As it became possible to provide more effective care to seriously ill patients, small infirmaries were developed in communities, sometimes associated with physician's offices, other times established by churches or social agencies.

Only gradually did medical specialization advance. The lack of effective interventions, facilities and support personnel prohibited effective specialization as we would know practice in the modern era. Particularly difficult cases that were not immediately life-threatening could be referred to a hospital in a larger community, or even a health care facility affiliated with a medical school.

As communities grew in population, however, and the number of physicians increased within communities, a new phenomenon became commonplace: the development of physician partnerships. Undoubtedly many individuals found that they had greater interactions with colleagues in the hospital setting or in the community, leading to informal consultation regarding patients. A partnership became a mechanism to formalize that interaction. The partnership also provided a way to assure a greater flexibility in the practice. The sole practitioner generally was a "captive" to practice as long as the person was accessible to patients, mainly whenever the person remained in the community. While most practices had scheduled office hours, it was almost impossible to turn away people from the door at anytime of the day or night, or respond to a request for a call to the patient's home. While some doctors thrived in this hectic life, others were exhausted and became weary of always being subject to the call of patients. The forming of a partnership enabled some sharing of after-hours responsibilities even prior to the common use of the telephone as an extension of personal communication. While not universal, partnerships of physicians became very common in all but the smallest communities and towns.

By early in the 20th century, it became possible for physicians of different specialties to come together in partnerships where there were practice associations. Physicians came together in practices due to their shared values and common practice styles. They learned the stability of the community's physician resources could be enhanced in a group setting that could provide greater amenities in practice and support in physician recruitment and replacement. In larger communities, multi-specialty groups also formed the basis for establishing a preferred relationship with hospitals and even a (at least perceived) competitive advantage in relationship to other physicians or groups. The aggregation of physician revenues also facilitated administrative options unavailable to solo practitioners or small groups. These included more sophisticated facilities, the provision of improved professional benefits (health insurance, disability insurance, retirement plans and other advantages) as well as the group purchase of liability insurance and special hospital staff arrangements.

In Iowa, almost every community of any size included at least one multi-specialty group practice. The number and diversity of physicians varied. Smaller communities might only have two or three specialties in a group, whereas in the larger cities the groups could include a dozen or more specialists in particular during the past several decades as medical and surgical specialists, have been produced in greater numbers in established community practice.

IOWA PHYSICIAN distinctions & AWARDS

MARY ANN ABRAMS, MD, was elected to the Executive Committee of the AAP section on Community Pediatrics.

JAMES BELL, MD, is a member of the Flying Physicians Association.

JEFFREY BOYLE, MD, was quoted in the *Des Moines Register* article, "Doctor touts value of ultrasound."

TOM EVANS, MD, was named vice president and chief medical officer for Iowa Health System. He was also featured in the "Do you know" column of the *Des Moines Register*.

HUNTER FUERSTE, MD, and his American Vintage Orchestra will perform in "Swing Out! The Big Band Show" October 26-29, 2000. For ticket information, call (319) 588-1305.

RUSSELL SCHURTZ, MD, was elected chair of the MMC Foundation—North Iowa Board.

MICHAEL SPARACINO, DO, was elected vice chair of the MMC Foundation—North Iowa Board.

JACK STAPLETON, MD, was named director of the Helen C. Levitt Center for Viral Pathogenesis and

Disease at the University of Iowa College of Medicine.

JOHN SUTHERLAND, MD, was quoted in "Managed continuity of care: A solution in search of a problem" in *Medical Economics*.

DECEASED MEMBERS

DAVID FREED, MD, 73, life, family practice, West Union, August 26, 1999

HARRY MARINOS, MD, 86, life, internal medicine, Mason City

THEODORE SCHRLETIS, MD, 75, life, pediatrics, Des Moines, December 29, 1999

SAMUEL WILLIAMS, DO, 64, emeritus, emergency medicine, Bettendorf, December 14, 1999

IMS welcomes NEW MEMBERS!

new practicing physicians

Mark Barnard, MD, Waterloo
Kyle Christianson, MD, Cedar Falls
Louis House, MD, Waterloo
Gary Knudson, MD, Waterloo
Wilbert Pino, MD, Waterloo
Michael Berstler, MD, Waverly
Frederick Asmussen, MD, Dubuque
Cynthia Konz, MD, Dubuque
Kenzo Sato, MD, Dubuque
David Haase, MD, Cresco
Sherry Kolacia-Tighe, MD, Monticello
David Burdette, MD, Cedar Rapids
Ronald Dose, MD, Cedar Rapids
LeAnn Larson, MD, Cedar Rapids
Brian MacGillivray, MD, Hiawatha
Paul Schneider, DO, Cedar Rapids
Gary Schweiger, MD, Cedar Rapids
Shabana Parvez, MD, Lake City
Linda Babbitt, MD, Mason City
Denise Lenarz, MD, Mason City
Daniel Pennington, MD, Mason City
Daniel Schupp, MD, Mason City

Mary Lou Ernst-Woodhouse, DO, Webster City
Jeffrey Meyer, MD, Webster City
Robin Meyer, DO, Eagle Grove
Donald Woodhouse, MD, Webster City
David Smith, MD, Fort Dodge
Michael Engle, DO, Marshalltown
John McCarville, DO, Marshalltown
Timothy Raleigh, DO, Marshalltown
Collyer Ekholm, MD, Ames
Firas Salti, MD, Ames
Marvin Swanson, MD, Ames
Lane Turner, DO, Ames
Shafiqul Alam, MD, Gowrie
Edward Miller, MD, Fort Dodge
Randall Minion, MD, Fort Dodge
Jeffrey Goree, MD, Sioux City
Sherill Purves, MD, Sioux City

Ralph Tullo, MD, Sioux City
Paul Thomas, DO, Eagle Grove
Christopher Caldarone, MD, Iowa City
Michael Cohen, MD, Iowa City
Tara Hata, MD, Iowa City
David Kusner, MD, Iowa City
Jeffrey Murray, MD, Iowa City
Shiliang Sun, MD, Iowa City
Tyrone Whitter, MD, Iowa City
Ekhard Ziegler, MD, Iowa City
Steven Fowler, MD, Dewitt
Peter Laureijs, MD, Dewitt
Mel Marilim, MD, Dewitt
Olufemi Oladele-Ajose, MD, Burlington
Michael Foggia, II, DO, Davenport
Blair Foreman, MD, Davenport
Ricky Garrels, MD, Eldridge
Richard Weyman, IV, MD, Davenport



Lance Wessling, DO, Washington
Sanda Cepoi, MD, Panora
Bruce Ricker, DO, Mount Ayr
Thomas Jensen, MD, Newton
Eric Cheung, MD, Ottumwa

new residents

Douglas McLaws, DO, Des Moines
Valerie Leong, MD, Iowa City

Members of the Iowa Medical Society join in welcoming the following new members into a progressive state medical association. The core purpose of the IMS is to assure the highest quality of health care in Iowa through our role as physician and patient advocate. Each new member is encouraged to join other IMS members at both local and state levels in achieving these goals.

300 bills in the General Assembly

In 1850, Iowa had no code but session laws creating state roads, authorizing ferry operations and restraining cattle from running at-large. Except for the grant of land to house the medical department at Iowa University and grant of authority to issue doctorate of medicine degrees, the General Assembly said nary a word about health care and medical practice.

Times have changed. The 78th General Assembly is in its second year, and the IMS is following nearly 300 bills involving medicine and public health.

MEDICAID REIMBURSEMENT

IMS continues to argue for \$6 million in state dollars to bring physician Medicaid payment up to Medicare levels. Key lawmakers are supportive, but all providers are asking for payment relief. The debate centers on the price tag, which is large.

Jessie Rasmussen, director of the Department of Human Services, says provider increases are not the answer to a broken system. She is proposing what she sees as a Medicaid network system under which state resource brokers would contract with provider networks to pay for identified results on a benchmark basis.

After prodding by IMS, Rasmussen agreed that this proposal, similar to one unsuccessfully introduced by her in Nebraska, was premature. Even so, Rasmussen is asking the legislature for incentive funding for targeted Medicaid programs in prenatal, dental and pharmacy case management.

IMS supports presumptive eligibility and continuous eligibility for Medicaid children but, again, the price tag places them in jeopardy.

TOBACCO DOLLARS

This partisan debate is close to resolution. IMS supports using all dollars for health care, including a comprehensive tobacco prevention and cessation program and funds for augmenting Medicaid physician payments. Public health programs were pitted against Medicaid provider increases. Appropriations at the end of the session will decide where the money — about \$55 million a year for the next 25 years — will go this year.

STATE MEDICAL EXAMINER

IMS believes a separate facility for the state medical examiner is essential. Unfor-

tunately, the \$10 million needed has not been budgeted. Appropriation debates may free up state infrastructure dollars for this purpose.

MENTAL HEALTH PARITY

Legislation mandating large group coverage for identified biologically-based mental illnesses, benefit minimums of 30 inpatient days and 52 outpatient visits, and copays and deductibles similar to medical services, passed the House and out of Senate Committee. IMS supports the bill as a step in the right direction.

LAY MIDWIFERY

Legislation calling for state licensure of direct-entry, non-medically-trained lay midwives but failed the last funnel. IMS opposes this legislation.

ASSIGNMENT OF INSURANCE BENEFITS

IMS actively lobbied to pass legislation requiring insurers to honor patients' assignment of insurance benefits. Wellmark opposed this bill and tried to add a prohibition against balance billing. The bill passed the Senate and awaits House debate.

OLD law, NEW bite

Mandatory ABUSE training

Renewing your medical license now requires you to state you have received abuse training

by Jeanine Freeman, JD

Since 1985, Iowa law has required mandatory reporters of child abuse to receive training (dependent adult abuse training was later required). Although enforcement mechanisms were not placed in these laws, their mandate is clear — mandatory reporters of child and dependent adult abuse must receive training.

REQUIREMENTS

All physicians are mandatory reporters but not all physicians must be trained. Physicians "whose professional practice does not regularly involve providing primary health care" to children or to adults are exempt

from the requirement.

Within one month of employment, physicians subject to the training mandate, must obtain a statement of abuse reporting requirements from their employer or, in the case of self-employment, from the Department of Human Services (DHS).

Both training mandates require two hours of training within six months of initial employment for physicians providing primary health care to either children or adults. Physicians then need to complete two hours of additional training for each five years in practice. If you regularly care for children and adults, you may combine training if the course has received prior approval for this purpose from DHS.

RESPONSIBLE PARTY

When a physician is an employee, the employer is responsible for providing the training. If the physician is

self-employed, the physician is responsible for obtaining the training. *Note: The IBME license renewal form does not distinguish between employed and self-employed physicians.* Physicians likely cannot avoid the training requirement because their employer did not provide it.

TRAINING OPTIONS

- DHS training video
- Hospitals or public agencies staff training
- Approved continued education program

DOCUMENTATION

Keep a record of the date, hours and name and method of instruction.

IBME'S ROLE

The IBME wants to assure physician compliance with the law but does not monitor the training. A physician who has scheduled but not yet received training may note that on the renewal application for processing purposes.

CHILD/DEPENDENT ADULT ABUSE TRAINING CONTACTS

North Iowa Area Continuing Education
Regional Health Education Center —
Paula Halverson (515) 422-7286

Department of Elder Affairs — Deanna
Clingan-Fischer (515) 281-4657

Genesis Medical Center — Marge
Imbrock (319) 421-2286

Iowa Geriatric Education Center —
Linda Seydel (319) 353-5756

Department of Human Services/Child
Abuse Wayne McCracken (515) 281-
8978

Department of Human Services/
Dependent Adult Abuse — Sandy Cole
(515) 281-6219

Local DHS office

Community colleges

Local hospitals and health facilities



Jeanine Freeman is vice president of public policy and advocacy for the Iowa Medical Society. Information in this column is not intended to be legal advice. Call your attorney with specific questions or concerns.

THROCKMORTON SURGICAL SOCIETY,
IOWA CHAPTER - AMERICAN COLLEGE OF SURGEONS
and
IOWA ACADEMY OF SURGERY

ANNUAL SPRING MEETING

SURGICAL SYMPOSIUM ON ONCOLOGIC SURGERY

APRIL 14-15, 2000

**Central Iowa Health System - Education Center
1415 Woodland Avenue
Des Moines, Iowa**

THROCKMORTON SURGICAL SOCIETY FACULTY (Friday - April 14)

James G. Blythe, M.D., FACS
Gynecology Oncology Surgical Services
Central Iowa Health System

James R. Howe, M.D.
The University of Iowa College of Medicine

Daniel R. Kollmorgen, M.D.
Iowa Methodist Medical Center

Mark S. Roh, M.D., FACS
Pittsburgh-Allegheny Hospital

Jay L. Grosfeld, M.D., FACS
University of Indiana School of Medicine
Riley Hospital for Children

Peter Jochimsen, M.D., FACS
The University of Iowa College of Medicine

Daniel L. Miller, M.D., FACS
Mayo Clinic

Merrick I. Ross, M.D., FACS
University of Texas M.D. Anderson Cancer Center

THROCKMORTON SURGICAL SOCIETY TOPICS (Friday - April 14)

Inherited Colon Cancer
Skin Sparing Mastectomy
Neuroblastoma and Wilms' Tumor
Recent Developments in Management of Melanoma
Liver Tumors in Children

Breast Cancer: A Century of Progress Leading to the Millenium
Update on Gynecology Oncology

Gene Therapy and Liver Tumors
Multi-Modality Treatment of Lung Cancer
Technical Aspects of Liver Resection
Surgery Management of Barrett's Esophagus
Update on Soft Tissue Sarcomas

**IOWA ACADEMY OF SURGERY/AMERICAN COLLEGE OF SURGEONS - IOWA CHAPTER
(Saturday - April 15, 2000)**

Presentation of Surgery Resident Paper Competition and following speakers and topics:

James G. Blythe, M.D., FACS
Robert M. Kuhl, M.D., FACS

Michael Foley, M.D.
Philip Caropreso, M.D., FACS

TOPICS

A Case of Rectal Carcinoma with Extensive Colonic
Polyposis and Surgical Treatment Options
Ovarian Tumors and the General Surgeons

Difficult and Interesting Complex Cases at a County
Hospital
Chronic Abscess Suprapubic Area Abdominal Wall

ACCREDITATION

This activity has been planned and implemented in accordance with the Essentials and Standards of the Iowa Medical Society through the joint sponsorship of the Central Iowa Health System (Methodist & Lutheran/Blank Children's) and Throckmorton Surgical Society. The Central Iowa Health System (Methodist & Lutheran/Blank Children's) is accredited by the Iowa Medical Society to provide continuing medical education for physicians.

The Central Iowa Health System (Methodist & Lutheran/Blank Children's) designates this educational activity for a maximum of 6.75 hours for 4/14 and 3.5 hours for 4/15 in category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

COST

Physician Fee \$150.00
Resident Fee \$35.00



CONTACT

Marcia Langstraat, Executive Secretary (TSS)
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HERO OF FLIGHT 232

Captain Al Haynes' skill helped to save many lives in the Sioux City crash of Flight 232. He credits the medical community in Sioux City as one reason so many lives were saved.

He will speak following dinner at the IMS Awards Banquet Friday, April 14.



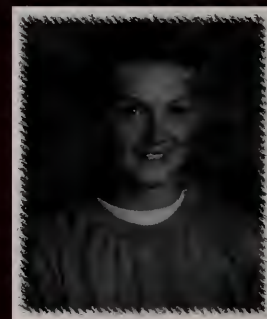
PHYSICIAN FACES DEATH ON EVEREST

Dr. Beck Weathers was left for dead on Mount Everest. Hear his unbelievable story of survival immediately following the IMS noon luncheon on Saturday, April 15. His gripping tale has received rave reviews from national audiences.

A CHILD IN DESPERATE NEED

In 1997, Ryan Tripp rode his lawnmower across the country to set a world record and raised \$15,000 for a little girl in Utah who was in desperate need of a liver transplant.

In 1999, Ryan promoted organ and tissue donation awareness by mowing the lawn at every state capitol.



RUNNING FOR SOMEONE'S LIFE

Rashad Williams raised \$18,000 for Columbine High shooting victim Lance Kirklin who did not have health insurance, by running the Bay-to-Breakers race in San Francisco. According to his mother, her son said, "He may be in a wheelchair the rest of his life. All I have to give him are my two legs."

SMILE . . .

Operation Smile provides funds for operations for children with facial deformities. Jennie Lillis heads up the Operation Smile Chapter at Dowling High School in West Des Moines which is raising money to help lower income families pay for cleft palate operations for their children.



Choices, stimulation, entertainment, convenience, networking, quality technology, an informative array of exhibits, cutting-edge medical education programs — the 2000 Iowa Medical Society Annual Meeting, April 14-16, 2000 at the downtown Des Moines Marriott has it all for Iowa physicians!

2000 IMS Annual Meeting the best yet...

SCHEDULE OF EVENTS

Friday, April 14, 2000

Specialty Society meetings all day.

- 6 p.m. IMS Reception
7 p.m. IMS Awards Banquet
featuring Captain Al Haynes
(see left)

Saturday, April 15, 2000

- 7 a.m. Registration
8 a.m. Population Trends
8 a.m. House of Delegates
Opening Session
8:45 a.m. Physician Workforce Trends
9:30 a.m. Break/tour exhibits
10 a.m. Genetic Treatments for Cancer
10:45 a.m. Professionalism and Ethics in
the New Millennium
11:30 a.m. Break/tour exhibits
Noon Mirade on Mount Everest
featuring Dr. Beck Weathers
(see left)
1:45 p.m. New Generation Heroes and
Role Models featuring Ryan
Tripp, Rashad Williams, Jennie
Lillis (see left)
2:30 p.m. Iowa Trauma System
3:15 p.m. Break/tour exhibits
3:45 p.m. COBRA/EMTALA: Requirements
for Medical Staff
4:30 p.m. Communicating Bad News
5:15 p.m. Adjourn
6 p.m. President's Reception
7 p.m. IMS Sesquicentennial
Celebration Dinner/Dance

Sunday, April 16, 2000

- 8 a.m. House of Delegates
Final Session

REGISTER TODAY!

IMS Annual Meeting Registration

Please complete the following information for the IMS Annual Meeting. (PRINT CLEARLY).

CHECK ONE: ☐ IMS MEMBER ☐ NON-MEMBER ☐ RES/STUD

☐ MD ☐ DO ☐ other

FIRST NAME LAST NAME

SOCIAL SECURITY NUMBER FOR CME PURPOSES

☐ Alliance member

GUEST NAME

TITLE

SPECIALTY

ORGANIZATION

ADDRESS

CITY

STATE

ZIP

TELEPHONE

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If you require special accommodations to fully participate,
please attach a written description of your needs.

PAYMENT INFORMATION

☐ Enclosed is my check payable to the

Iowa Medical Society for \$ _____

☐ Please bill my credit card for \$ _____ ☐ Mastercard ☐ VISA

CREDIT CARD NUMBER

EXPIRATION DATE

CARDHOLDER SIGNATURE

INDIVIDUAL EVENTS	MEMBER*	NONMEMBER	RESIDENT	STUDENT	NUMBER OF TICKETS	TOTAL
Friday, April 14						
IAFP sponsored education	\$25.00	\$25.00	\$25.00	\$25.00		
IMS Awards Banquet	\$50.00	\$75.00	\$25.00	\$25.00		
Saturday, April 15						
IMS Educational Program	\$60.00	\$120.00	\$25.00	waived		
Beck Weathers, MD Luncheon	\$25.00	\$40.00	\$25.00	\$25.00		
IMS 150th Dinner/Dance	\$50.00	\$75.00	\$25.00	\$25.00		
Subtotal						
Adopt-A-Physician rebate	First-time physician's name _____					-25.00
Total enclosed						

* Member prices are extended to one guest.

Questions: Call Becky Bales at (800) 747-3070.

To register with credit card: Complete this form and fax to (515) 223-8420 Attn: Becky Bales

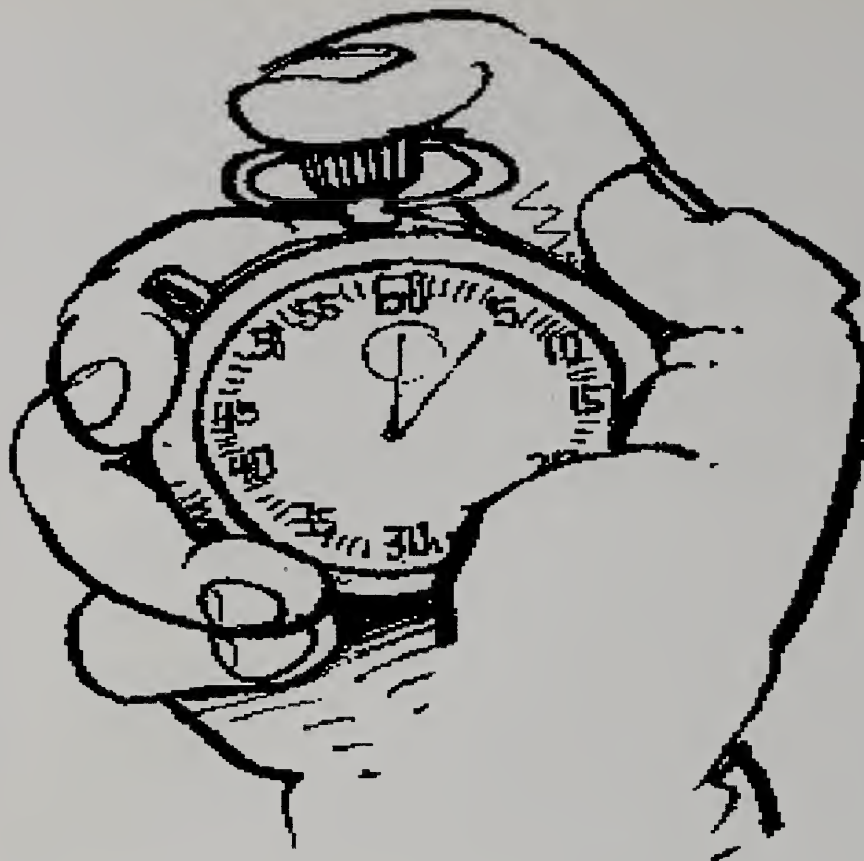
To register by mail with check or credit card: Mail completed form and payment to IMS Annual Meeting, 1001 Grand Avenue, West Des Moines, IA 50265-3502

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Allocating your portfolio after **RETIREMENT**

Evaluate your needs before allocating your portfolio before and after retirement.

by Jerry Foster

Among the many concerns that plague individuals upon retirement, how to allocate investment portfolios often generates some of the highest interest.

After retiring, you have many options to consider in reallocating your investment portfolio. You could convert your portfolio to income-producing securities, thus creating a need for clipping coupons for the rest of your life due to the fear of inflation. Or you could design a portfolio full of high return securities, which protects your portfolio from inflation risk, but the volatility of such a portfolio sends you to the

Internet or watching the market news in fear of losing all that you have worked so hard to accumulate.

As I have discussed in previous articles, most people have an expectation from their portfolio that is based on greed or fear. The only way to overcome the power of these two emotions is through a comprehensive retirement plan.

Once a "required" rate of return is established, portfolio design and distribution strategies can be formulated. If a seven percent return is required, then a couple of questions can be asked that can help you work through the market frenzy and temptation to chase after the higher returns.

How would your life change if you could have an 11 percent annual return? If your life wouldn't change, does it make sense to take meaningful risk to try to get from seven percent to 11 percent?

Suppose you went through the next 10 years and experienced zero percent real returns. How would this change your spending habits?

Most people fit somewhere between. With this in mind, it makes sense to allocate your portfolio to fit your current needs and continually assess your situation in light of market conditions. In the early years, your time horizon is longer, and the need to offset the effects of inflation is greater.

Thus, a higher percentage of equities is appropriate. Allocating at least two-four years of income into fixed investments gives you a cushion during down periods in the equity markets, therefore avoiding the need to liquidate equities at losses.

As needs change, your allocation should change, thus creating a strategy based on anticipation rather than reaction.



Jerry Foster is the CEO of Foster Capital Management, a fee-only financial planning and investment management company located at IMS headquarters, (800) 798-1012.

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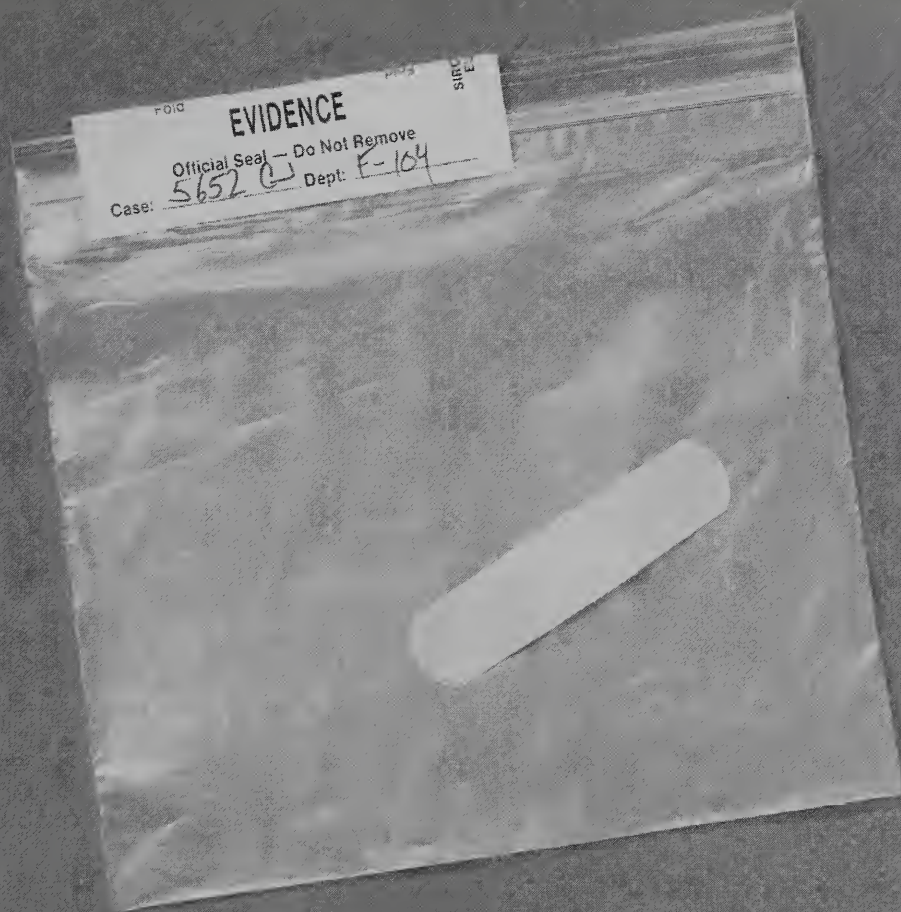
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*e*xhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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ANNOUNCES 2000 CANDIDATES

The Iowa Medical Society (IMS) Nominating Committee met on Wednesday, February 9, 2000 to assemble a slate of candidates for various offices to be voted on during the 2000 IMS Annual Meeting at the downtown Des Moines Marriott, April 14-16, 2000. Nominations will also be taken from the floor at the House of Delegates session on Saturday, April 15.

2000 IOWA MEDICAL SOCIETY NOMINATIONS

- **President-Elect** (1 seat, 1-year term) — Hunter Fuerste, MD, Dubuque
- **At-Large Directors** (2 seats, 3-year terms)
Phillip Alscher, MD, Mason City
James Hubbard, MD, Dubuque
Leo Milleman, MD, Ames
- **Speaker, House of Delegates** (1 seat, 1-year term)
Tom Throckmorton, MD, Spencer
- **Vice-Speaker, House of Delegates** (1 seat, 1-year term)
John Sutherland, MD, Waterloo
- **AMA Delegates** (2 seats, 2-year terms to begin 1/1/01)
R. Bruce Trimble, MD, Mason City
Donald Young, MD, Iowa City
- **AMA Alternate Delegate** (1 seat, 1-year term to begin 1/1/01)
William McMillan, MD, Ottumwa
- **Nominating Committee** (2 seats, 2-year terms)
Paul Berger, MD, Sioux City
Steven Jacobs, MD, Cedar Rapids

IMS alliance

There is life in the 21ST CENTURY

It is hard to believe the new year has come and gone. I know my family shared a collective sigh when there was still heat and lights at 12:01 a.m., January 1, 2000. Most people bought into the "End of Life as we know it" scenario. After all, we heard about it daily on TV and radio. Fear led people to buy mountains of tuna, canned soups, and water. The first question we asked was not what happened, but why nothing happened?

Analysts said little happened because the media created a demand for measures

to keep our country safe and functioning. With this impetus, the world worked feverishly to make sure nothing happened.

This is the part that confuses me. After all, didn't anyone notice the millennium was coming? It had been 1000 years since the last one, but we do have calendars. All the work to make us Y2K compliant worked. But, sadly, as we all rushed around preparing for the disaster, we were unable to enjoy a truly wonderful moment in our history.

That is why I am so glad

the Iowa Medical Society has taken the opportunity to look back to honor IMS medicine in the 20th Century and to plan forward to greet the 21st Century of medicine. This year is the 150th anniversary of the IMS. No, it is not 2000 years, but it is a grand accomplishment! Siroos Shirazi, IMS president, the IMS Board and committees worked hard to make this Annual Meeting Celebration a memorable 150th affair. I hope all IMS and IMSA members don't miss the opportunity to celebrate this anniversary too.



This article was written by Gail Sands, IMSA president



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860 22nd Avenue
Coralville 52241
(319) 338-8000

ALLERGY

◆Pediatric and Adult Allergy, PC

Veljko K. Zivkovich, MD
Robert A. Colman, MD
1212 Pleasant, Suite 110
Des Moines 50309
(515) 244-7229

Asthma, Allergy & Immunology

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◆Bariatric Surgical Weightloss Program

John A. Stoner, MD
3801 N. Marquette, Suite 307
Davenport 52806
(319) 388-0885 or (888) 477-9187

CARDIAC SURGERY (ADULT AND PEDIATRIC)

◆Iowa Heart Center

Robert H. Zeff, MD
David R. Hockmuth, MD
Clay E. Beggerly, MD
Mark G. Nelson, MD
Bart P. Jenson, MD
Cham Kongtahworn, MD

411 Laurel, Suite A250
Des Moines 50314
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1301 Pennsylvania Ave., Suite 115
Des Moines 50316
(515) 263-0900 or (888) 591-9248

1215 Pleasant Street, Suite 414
Des Moines 50309
(515) 241-8033 or (888) 591-9249

CARDIO-THORACIC SURGERY

◆Heart & Vascular Care

The Iowa Clinic, PC
Hooshang Soltanzadeh, MD
Ronald K. Grooters, MD
Kent C. Thieman, MD
Robert F. Schneider, MD
1440 Pleasant Street, Suite 150
Des Moines 50314
(515) 241-5735

CARDIOLOGY

◆Heart & Vascular Care

The Iowa Clinic, PC
Chad L. Williams, MD
David Lemon, MD
Jay Yans, MD
Dirk A. Ver Steeg, MD
James P. Lovell, DO
Martha J. Stewart, MD
Frank N. Haugland, MD, PhD
Allan Latcham, MD
Jonathan Fudge, MD
1440 Pleasant Street, Suite 200
Des Moines 50314
(515) 241-5988

◆Iowa Heart Center at Mercy

411 Laurel St., Suite A250
Des Moines, IA 50314
(515) 235-5000 or (800) 532-1844
David F. Gordon, MD
L. A. Iannone, MD
William J. Wickemeyer, MD
Randolph R. Rough, MD
Magdi G. H. Ghali, MD
Craig A. Stevens, MD
W. Ben Johnson, MD
Mark A. Tannenbaum, MD
Steven J. Bailin, MD
S. V. Advani, MD, PhD
Richard H. Marcus, MD
Marc L. Klein, MD

Iowa Heart Center at Lutheran
1301 Pennsylvania Ave., Suite 115
Des Moines 50316
(515) 263-0900 or (888) 591-9248

Timothy T. Hart, MD
Amar Nath, MD
Robert H. Hoyt, MD
Denise M. Sorrentino, MD
John M. Pargulski, DO

Iowa Heart Center at Methodist
1215 Pleasant Street, Suite 414
Des Moines 50309
(515) 241-8033 or (888) 591-9249

Mark D. McGaughey, MD
Philip Bear, DO
Robert H. Hoyt, MD
Kevin E. Crowe, MD
Craig A. Stark, MD
David R. Laughrun, MD
Samir Zafar, MD

Iowa Heart Center at Mercy West
1601 NW 114th Street, Suite 330
Des Moines 50325
(515) 222-1166 or (888) 591-9247
Thomas M. Brown, MD
Joel A. From, MD
Margaret H. Verhey, MD
Jeffrey J. Boyd, MD
Michael R. Muellerleile, MD
Mark S. Bissing, DO

Iowa Heart Center at St.
Anthony's
405 S. Clark Street, Suite 205
Carroll 51401
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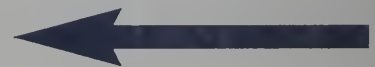
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Assignment of benefits bill is **PRIORITY** for **IMS**

Passage of legislation (SF 2203) requiring insurers to recognize a patient's right to assign insurance payment to providers passed the Senate Commerce

Committee. At press time, after intense lobbying by the IMS, the bill survived the

March 17 funnel.

Research so far shows that Wellmark is the only Iowa

Wellmark is the only Iowa insurer that prohibits subscribers from agreeing to assignment of benefits to non-participating providers.

insurer that prohibits subscribers from agreeing to assignment of benefits (to

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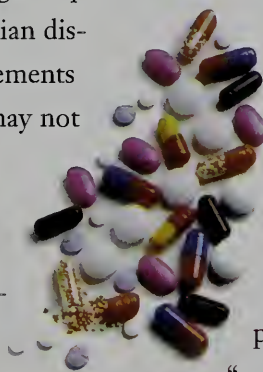
The 1999 IMS House of Delegates directed that the IMS work on passing assignment of benefits legislation.

The IMS is working with the Iowa Hospital Association on the legislation. Wellmark will strongly oppose the bill.

Please email your senator at FirstName_LastName@legis.state.ia.us and voice your support for this important bill.

BME GIVES green light to office prescription services

Physicians have been authorized by the Iowa Board of Medical Examiners to use office prescription services so long as the physician complies with legal requirements for physician dispensing. Requirements are: physicians may not operate a retail pharmacy; physicians who delegate dispensing to a staff assistant must personally verify the accuracy and completeness of a prescription; physician dispensers must register with the IBME and physicians must offer patients a choice of pharmacy.



The issue of physician office prescription services was brought to the attention of the BME when pharmacist groups complained about the use of Allscripts in Iowa clinics and asked the Board to issue a ruling. IMS advocated for physicians on the issue.

One Iowa physician who uses the office prescription service says "patients love it."

Contact Cheryl Peers at the IMS, (800) 747-3070 or email her at cpeers@iowamedicalssociety.org for a copy of the BME letter outlining requirements for physician dispensing.

New STATE MEDICAL EXAMINER at work

Julia Goodin, MD began in December as the new state medical examiner. An advisory council has been formed (provided for in 1999 legislation drafted by IMS). The IMS representative is John O'Connor, MD, Dubuque.

Interviews are underway for a deputy medical examiner. IMS is lobbying for funding requests for a new facility and equipment. Governor Vilsack did not recommend funding for the proposed \$10 million facility in his budget.

Dr. Goodin recently met with the IMS legislative planning committee, the board of the Iowa Association of County Medical Examiners and the Iowa Society of Pathologists.



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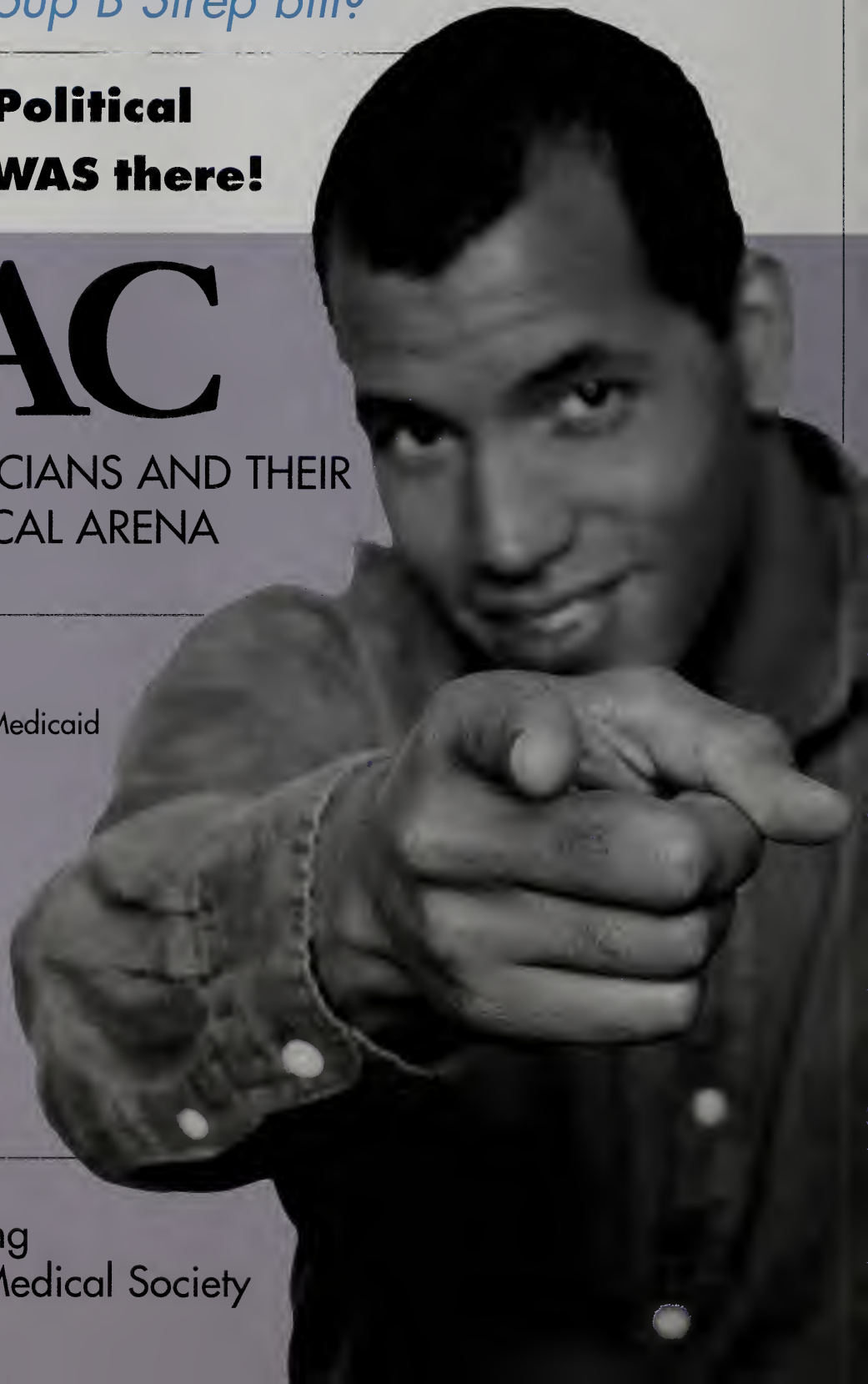
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AMA supports patient safety goals

The AMA supports President Clinton's goal of reducing health system errors and improving patient safety, and we agree with many of his proposals.

However, we are concerned that the proposal for mandatory reporting will not improve patient safety and may, in fact, have the perverse result of driving errors underground. Effective aviation safety programs have taught us that a culture of safety is created by avoiding a culture of blame. The same principle holds true for the health system.

The AMA and the medical specialty societies have been pioneers in the effort to reduce health system errors. Based on our work, we agree with many of the President's proposals for steps the private sector and government can take to improve patient safety.

We support the President's call for increased funds to research errors and disseminate the findings to improve health care. We also concur with the proposal to modify pharmaceutical packaging and marketing practices to reduce medication errors. Prompt action is needed on

many consensus areas for improving patient safety.

However, the AMA is opposed to the expansion of mandatory reporting of medical errors. There is no evidence to show mandatory reporting improves patient safety. Before we expand data collection activities we need to analyze existing state systems to determine the most effective use of finite resources.

The AMA appreciates President Clinton's statement of support for protecting the

confidentiality of peer review activities. But we are concerned that the protections do not go far enough to promote the type of information sharing that would help create a culture of safety where all members of the health system can learn from and prevent errors.

— Nancy Dickey, MD
AMA Immediate
Past President



how we learn

GENERATIONS of physicians

A sesquicentennial commemoration encompasses about five generations. A few Iowans, offspring of the earliest European-Americans to settle in this territory, can claim a progenitor who was a physician.

Somewhere in an attic or trunk, perhaps in a museum, the tools and other simple clinical equipment of those physicians still exist as reminders of mid-nineteenth century practice.

Physicians of that era were

largely trained by preceptors with only modest academic learning. They developed skills through experience. Their continuing education was limited.

As generations of physicians have subsequently gained their credentials, the modalities for learning have been revolutionized. The expectations of patients for professional competence are unyielding. The outcomes of care are often miraculous.

We've come a long way.



This column is written by Dr. Richard Nelson, executive associate dean, University of Iowa College of Medicine.

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Sept. 20 — Elder Abuse

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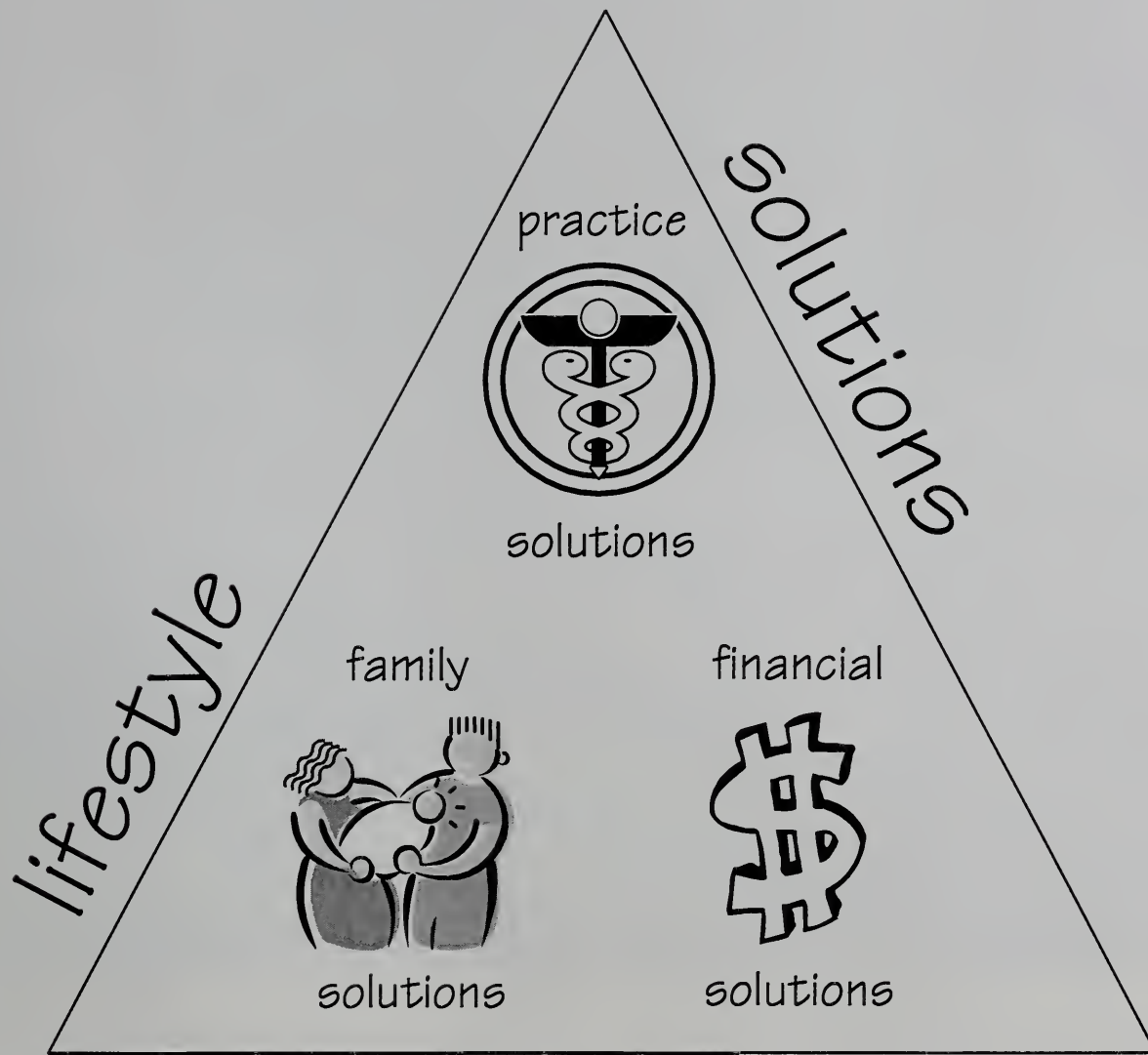
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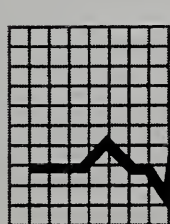
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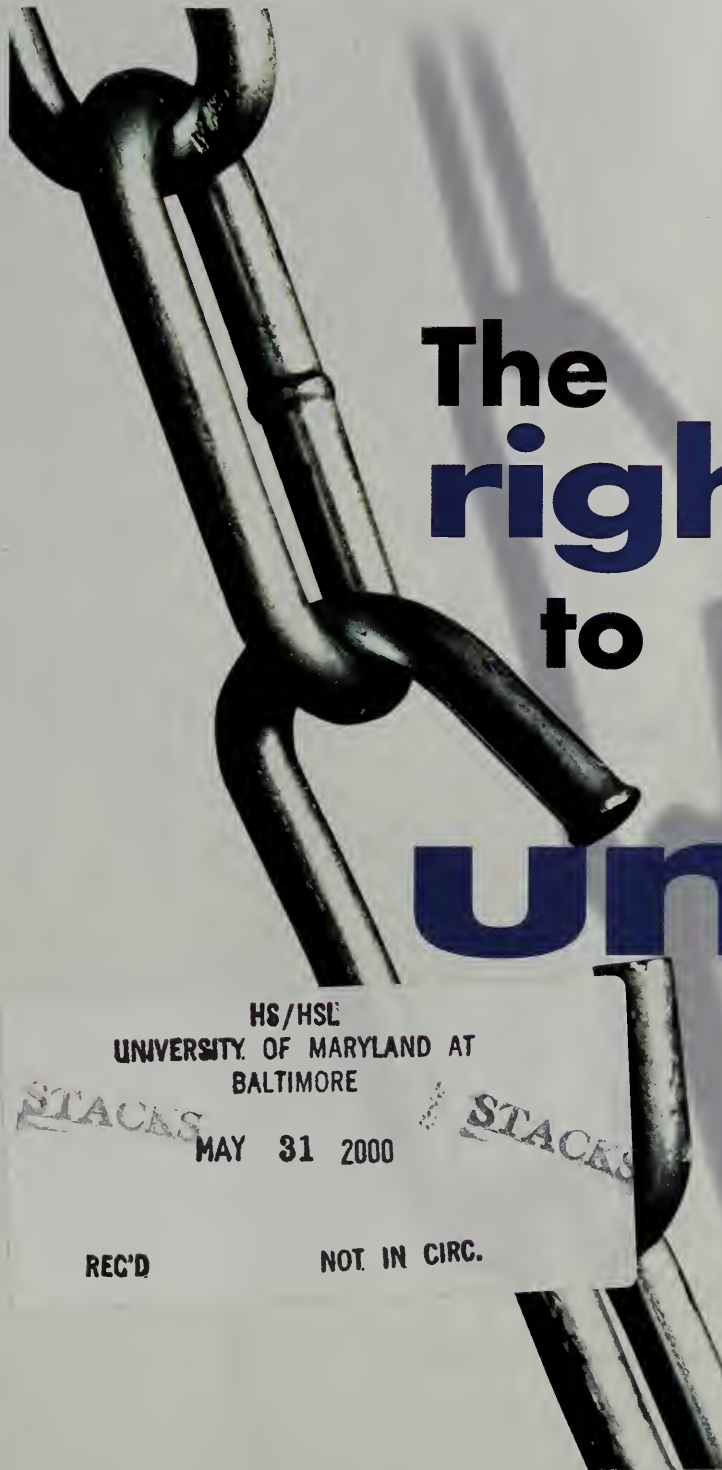
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NOT IN CIRC.

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IowaMedicine

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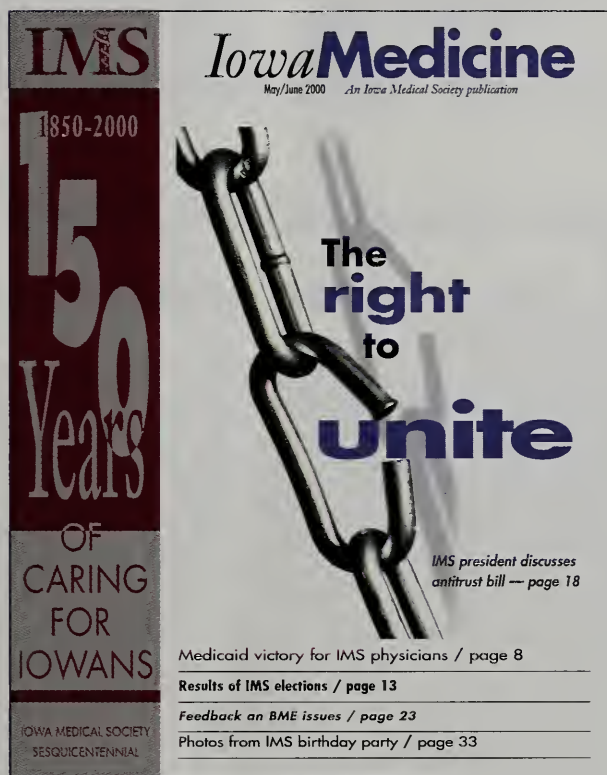
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We're losing the humanism in our profession, says this Des Moines physician.

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Photos from the Iowa Medical Society's 150th birthday party.



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WERE **you there when...**

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... IMS passed HIV/AIDS & state medical examiner bills?

... IMS killed the Group B Strep bill?

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- ✓ When we ask for a state medical examiners faculty?

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Let's change **APATHY** into **ADVOCACY**

Frustrated with the
practice of medicine?
Get active in making
changes! Join the IMS.

by Sterling Laaveg, MD

As I was growing up, Dr. Sam Leinbach, a past-president of the Iowa Medical Society, often encouraged me to consider a career in medicine. After I began medical training, Sam often sought me out. He would tell me, "You need to give something back to medicine for what it will do for you. Support our Iowa Medical Society (IMS) and our American Medical Association (AMA)."

Iowa physicians are frustrated with the practice of medicine. We have HMOs, IPAs, PPOs, ODSs and integrated networks. There are 44 million uninsured people in the U.S. HCFA is

redefining "fraud and abuse" daily. If it is not documented, it did not happen. Fewer physicians want to be involved in organized medicine.

We need to change that non-involvement attitude and light new fires. Please work with me to help our colleagues "give something back" and transform apathy into advocacy.

The IMS is actively working to make a difference in our patients' lives. The IMS staff monitors every health care regulatory meeting, watches every bill in the Iowa Legislature and U.S. Congress and lobbies heavily for our patients and the profession of medicine. Our Iowa Medical Society is the major health care advocate in Iowa.

This year we need your help to continue efforts to blunt the impact of health insurance companies on patient care; to continue to assist the Board of Medical Examiners in improving its

administration; to complete the implementation of the IMS strategic plan; and to continue to build the medical student legacy scholarship-loan fund in honor of our 150th year started by Siroos Shirazi, MD.

You are not apathetic, or you wouldn't be reading this magazine. The essence of being a medical professional is to be the patient's advocate.

We stand at the dawn of the new millennium this year. We celebrate the 150th anniversary of our Iowa Medical Society. The IMS wants to connect to every individual physician in Iowa. There is much to do. We can change things together. As your new president, I need your help and welcome your input.



Dr. Laaveg is an orthopaedic surgeon in Mason City and president of the Iowa Medical Society.



Hospitals **LOSE** money on fashion trend

Ever since medical scrubs became fashionable, hospital officials have been looking for ways to stop workers from swiping the loose-fitting tops and pants.

Several Chicago-area hospitals installed machines that don't hand out clean scrubs until the dirty ones have been returned.

Some blame the popularity of scrubs on television dramas such as "ER" and "Chicago Hope." Others feel it has become a status symbol to steal hospital scrubs. The clothes cost about \$12 to \$15 a set.

Another approach has been to make the scrubs simply less desirable. Northwestern Memorial Hospital put large, unattractive decals all over its scrubs. University of Chicago Hospitals changed the color

of their sets to a putrid looking bright purple.

Unfortunately, the purple scrubs became popular, and decals for highly respected hospitals gave the scrubs more street credibility.

Did you know...

One in every four primary care MDs worry about the care they are expected to provide to sicker patients and those with complex medical problems without referring them to a specialist. Primary care physicians most likely to report a too-broad scope of care were pediatricians and general internists in one- or two-physician practices, those who serve as gatekeepers for health care and those who receive capitation.

New England Journal of Medicine

X marks the spot

Your patient is under anesthesia. You quickly check your notes... right knee surgery.

After coming out of surgery, your patient still has the pain and looks down to see you operated on the wrong knee.

Wrong-site surgery is rare — the Physicians Insurers Association of America said of 155,000 malpractice claims filed, only 1,000 involved wrong-site claims.

This doesn't mean that it can't happen to you. So, do as Charles Clark, MD, an orthopaedic surgeon at the University of Iowa. A day or two before operating, meet with your patient, take out your indelible pen and write your initials on the surgery site.

2000-2010 — *the bone and joint decade*

A part of healthy living is keeping bones and joints strong. Without these structures, we wouldn't have any form or be able to perform any function.

Bones and joints are so important that professional medical associations, patient advocacy groups, governments, the Secretary General of the United Nations and even the Pope have declared 2000-2010, "The Bone and Joint Decade."

Stuart Weinstein, MD, University of Iowa professor

of orthopaedic surgery and IMS member, is serving as chair of the American Academy of Orthopaedic Surgeons task force on the bone and joint decade.

The hope is to raise awareness of the increasing societal impact of musculoskeletal injuries and disorders, empower patients to participate in the decisions about their care, increase funding for prevention activities and research and promote cost-effective prevention and treatment.

(Health News, UIHC, 2-2-2000)

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The gavel falls on the 2000 Session

Major Medicaid VICTORY for physicians

Legislators adjourned the second year of the 78th General Assembly session with compromises on many issues.

MEDICAID REIMBURSEMENT

Republican leadership and the Governor agreed to use \$6 million of Iowa's tobacco settlement dollars to bring Medicaid physician payment to Iowa Medicare rates and to implement a RBRVS payment methodology. Implementation will occur Nov. 1, 2000 to allow for adjustments in payment to physicians in managed care.

ASSIGNMENT OF BENEFITS

Physicians and hospitals lobbied for a requirement in law that all health insurers accept a patient's assignment of benefits. Senate File 2203 passed by overwhelming

bipartisan majorities in both the Senate and the House. The Governor, claiming cost considerations, vetoed the legislation, and a Republican-mounted override effort in the Senate was unsuccessful.

IMS leadership continues to search for effective private and public sector mecha-

nisms to address this issue.

STATE MEDICAL EXAMINER

IMS successfully gained a \$3.2 million General Services appropriation dedicated to a facility for the state medical examiner, DCI crime lab and Department of Public Safety offices. Legislators also approved operational increases for the state medical examiner. The state medical examiner was granted investigative powers to be used in coordination with local law enforcement authorities.

MIDWIFERY/PAs

IMS halted efforts to legally sanction the practice of medicine in Iowa by non-medically trained, direct-entry (lay) midwives and to expand the licensing authority of physician assistants.

IMS, however, is supporting changes to IBME rules to eliminate burdensome steps in the approval process for physician supervision of PAs.

MENTAL HEALTH PARITY

IMS supported House File 2080 — a bill mandating coverage by large group insurers for designated biologically-based mental illnesses with an annual minimum of 30 inpatient

days and 52 outpatient visits and parity in copayments and deductibles. The bill successfully passed the House and came out of Senate committee but never saw Senate floor debate.

TOBACCO SETTLEMENT

See page 32 for detailed information.

HAWK-I AND MEDICAID

Lawmakers agreed with the long-held IMS position that HAWK-I be funded at 200 percent of federal poverty but approved only a pilot on Medicaid continuous eligibility because of cost concerns. IMS will work with DHS to explore other administrative options for continuous eligibility.

REPORTING SPONTANEOUS TERMINATIONS OF PREGNANCY

IMS successfully negotiated bill language to eliminate this requirement in law and to implement less intrusive reporting rules. Senate File 2367 did not see final floor debate, in part to avoid amendments to overcome the Governor's veto of House File 2229, the informed consent abortion bill.



2000 Resolutions from the IMS House of Delegates

00-1 RESOLVED: That in order to clearly state a member may vote for one representative group and serve as a delegate or alternate delegate of another representative group and that his/her ballot be kept confidential, the Bylaws be amended, effective immediately.

00-2 RESOLVED: That the Iowa Medical Society promote dissemination of information on the housing and service needs of persons with severe mental illness who require long-term care.

RESOLVED: That the Iowa Medical Society promote the importance of community-based congregate housing with on-site professional services for those who are severely ill.

RESOLVED: That the Iowa Medical Society advocate for examination of this issue by the local and state Departments of Human Services and inform legislators of the need for legislation.

00-3 RESOLVED: That the Iowa Medical Society implement, at the 2001 House of Delegates, child care and other family friendly activities at no cost to the participants, provided that the cost to the IMS shall not exceed \$3,000 per year. These arrangements shall remain in effect for a minimum of three (3) years, after which the Board of Directors shall evaluate the success of these efforts.

00-4 RESOLVED: That in order to give Districts enough flexibility to meet so that proposed s may be included in the Delegate Handbook, the IMS Bylaws be amended, effective immediately to allow districts to caucus any time prior to the House of Delegates, and to allow the President to name district chairs prior to receiving names of delegates.

RESOLVED: That the Board of Directors study and clarify which slate of delegates is eligible to elect a district director prior to the upcoming House of Delegates, and report back at the next House of Delegates.

00-5 RESOLVED: That the Iowa Medical Society change the requirement of the component societies to forward an official report of its members, officers, delegates and alternate delegates to February 15 of the calendar year and modify the requirement of the component societies to forward a list of non-member physicians by amending the Bylaws, effective immediately.

00-6 RESOLVED: That the Iowa Medical Society exempt from term limitations any AMA delegate or alternate delegate holding a seat on an AMA council or any other AMA office by amending the Bylaws effective immediately.

00-7 RESOLVED: That the Iowa Medical Society support and advocate for state funding for proven and effective programs to reduce adolescent pregnancy in Iowa with emphasis in those areas of the state experiencing particularly high rates of adolescent pregnancy.

00-8 RESOLVED: That the Iowa Medical Society become informed about assisted living and advocate for state regulatory mechanisms that best assure a level and quality of care and support in these facilities appropriate to the health needs of the residents.

00-9 RESOLVED: That the issue of embryonic stem cell research and funding be referred to the IMS Board of Directors for study and recommendations by an ad hoc committee on IMS policy with a report back to the 2001 House of Delegates.

00-10 RESOLVED: That the IMS support current legislation which would require health insurance plans that currently provide a prescription benefit to cover prescriptions for contraceptives.

00-11 and 22 RESOLVED: That the IMS support legislative or regulatory efforts to enhance the drivers license organ donor check-off system for organ donation through the Iowa Department of Transportation, and that this system utilize an organ donation card that meets the legal standards outlined by the Uniform Anatomical Gift Act and which gives the individual the options of donation, non-donation or delegation of consent to the donor's next-of-kin;

RESOLVED: That the Iowa Medical Society convene a task force of interested parties to study the organ donation situation in Iowa and innovative approaches to increasing organ donation used successfully in other states. This task force will also work with the Iowa Department of Transportation to distribute the appropriate organ donor cards and facilitate voluntary signing at the time of new drivers' licensure, renewal and/or replacement.

00-12 (Medical Errors)

The Reference Committee recommends this be referred to the Board of Directors for decision.

00-13 and 20 RESOLVED: That the Iowa Medical Society, working with the specialty societies, continue to collaborate to move Medicaid to an RBRVS payment system, excluding anesthesia services; to increase payments to Medicare levels; and to keep this issue as a top legislative priority in 2001.

00-14 **RESOLVED:** That the IMS continue to pursue mandating insurance companies to accept a patient's assignment of benefits by all appropriate means.

00-15 **RESOLVED:** That the Iowa Medical Society work with organizations throughout the State of Iowa that credential physicians and/or pursue legislative remedies to streamline the credentialing and re-credentialing process.

RESOLVED: That the Iowa Medical Society actively promote the adoption of a standardized, universally acceptable short form for renewal or re-certification purposes that requests only changes from the original application as the first step to improving the credentialing and re-credentialing process.

00-16 **RESOLVED:** That the Iowa Medical Society advocate with the Department of Human Services that insurers administering Medicaid claims in Iowa be required to accept claims up to one year after the date of service.

RESOLVED: That the Iowa Medical Society introduce a similar at the 2000 American Medical Association annual meeting directing the AMA to advocate for a change in Health Care Finance Administration regulations concerning submission of claims for up to one year.

00-17 **RESOLVED:** That the Iowa Medical Society support educational campaigns to encourage the use of bicycle helmets.

RESOLVED: That the Iowa Medical Society support the adoption of mandatory bicycle helmet legislation for all bicyclists ages 14 and under in accordance with the national SAFE KIDS campaign.

00-18 **RESOLVED:** That the issue of protection or securitization of Iowa's tobacco settlement revenues be referred to the Tobacco Settlement Subcommittee of the IMS Committee on Public Health.

RESOLVED: That the Iowa Medical Society introduce a to the American Medical Association to encourage consideration of the pros and cons of various mechanisms to preserve the integrity of the tobacco settlement funds.

00-19 **RESOLVED:** That the Iowa Medical Society advocate for passage of legislation requiring third party payers to pay "clean" claims for health care services within 45 days.

RESOLVED: That the IMS defines a claim as "clean" unless the claimant is notified in writing of the additional information necessary to adjudicate the claim with reasonable specificity within ten days after initial receipt of the claim.

RESOLVED: That the IMS will advocate that interest will be paid to the party to whom the benefit check is assigned if a "clean" claim is not paid within 45 days.

00-21 **RESOLVED:** That the issue of mandatory physicals for children entering the ninth grade be referred to the School Health Subcommittee of the IMS Committee on Public Health for appropriate recommendations to achieve the objectives of this .

00-23 **RESOLVED:** That the Iowa Medical Society work with affected specialty societies and third party payers to develop appropriate, consistent and equitable methods for coding and reimbursing pain management services for all physicians.

00-24 **RESOLVED:** That anesthesiology is the practice of medicine.

RESOLVED: That the Iowa Medical Society seek legislation to establish the principle in state law and regulation that anesthesia care requires personal performance or supervision by an appropriately licensed and credentialed doctor of medicine, osteopathy or dentistry.

00-25 **RESOLVED:** That the Iowa Medical Society House of Delegates commend the invaluable service provided by Gary Peasley, MD as a member and Chair of the Iowa Board of Public Health.

00-26 **RESOLVED:** That the subject of current problems of the Iowa Board of Medical Examiners be referred to the IMS Board for further review, guidance, and action.

00-27 **RESOLVED:** That the IMS recommend to the Iowa Department of Inspections and Appeals a resource panel of physicians with training and experience in long term care to advise and assist the Department in the survey process.

00-28 **RESOLVED:** That the Iowa Medical Society, the Iowa Academy of Family Physicians and other health care organizations promote recognition of appropriate coding for concurrent evaluation and management and preventive medicine services and encourage appropriate reimbursement by third party payers as allowed per contractual benefit packages.

00-29 **RESOLVED:** That the Iowa Medical Society adopt policy and support legislation which would reduce the risk of injury and death from drowning and near-drowning for children and adolescents by requiring use of personal flotation devices while boating.

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Electronic Financial/
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May 7 and June 16, 1998

Health Care Provider
Identifier Standards

May 7, 1998

Employer Identifier
Standards

June 16, 1998

Security and Electronic
Signature Standards

August 12, 1998

Privacy of Indentifiable Health
Information Standards

November 3, 1999

Health Claim Attachment
Standards

Not yet published

Health Plan Identifier
Standards

Not yet published

Individual Identifiers

Not yet published

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*Jeanine Freeman is vice
president of public policy
and advocacy for the Iowa
Medical Society. Informa-
tion in this column is not
intended to be legal advice.
Call your attorney with
specific concerns.*

legalities

HIPAA is on its way... Be on the

WATCH

Watch out! More cum-
bersome rules are on the
way for physicians.

by Jeanine Freeman, JD

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a huge piece of federal legislation with far-reaching implications for physician practices.

HIPAA's goal is to enhance efficiency in health claims processing through use of electronic transmissions, standard formats and unique identifiers. Security and privacy rules are mandated to protect against confidentiality rules.

Physician compliance will require review of and change to computer hardware and software; forms; office policies and practices; third party contracts and agreements;

and personnel policies and training. IMS is developing materials and programs to assist its member physicians.

HIPAA's security regulations propose administrative procedures, physical safeguards and security measures to protect against interception of health data and access to stored health care information. In addition, electronic signatures must meet cryptographically based digital signature standards.

HIPAA's privacy rules apply to "protected health information" maintained or transmitted electronically even after that information is transferred to paper form. In addition, physicians must obtain reasonable assurances from their "business partners" (i.e., auditors, attorneys, billing firms, consultants) that they will comply with the HIPAA rules.

Use or disclosure of protected health information except as authorized by the

rule is prohibited. Protected health information may be disclosed for treatment, payment, or health care operations (i.e., quality assurance, physician credentialing) purposes without patient authorization. Only necessary information may be released, and specific authorization is needed to release psychotherapy notes. In addition, physicians must prepare and provide to their patients notice of information policies and practices.

HHS can impose a fine of \$100 for each violation of its HIPAA requirements with an aggregate of \$25,000 imposed in any one year against any one entity. Criminal sanctions of up to \$50,000 or imprisonment for one year may be imposed for wrongful disclosure of health information or use of a unique identifier.

Final rules are months away. Health providers must be in compliance within 24 months of the effective date.

AMA litigation center **STANDS UP** for physicians

Organized medicine is tired of being pushed around by managed care, according to AMA Trustee Donald Palmisano, MD, JD. "The AMA Litigation Center is an advocacy resource physicians and medical societies can go to for effective legal advocacy," Dr. Palmisano said.

The litigation center has filed high profile lawsuits against large insurance companies in New York and Georgia. However, these lawsuits represent only a small portion of the center's numerous efforts on behalf of the Federation and physicians in its five-year history. Here are just a few examples of pending cases and litigation center partnerships:

- **Maryland** — On behalf of the AMA and Maryland's state medical society, Med-Chi, the litigation center has intervened in a federal case where a patient sought mental health or substance abuse benefits from Blue Cross/Blue Shield of Maryland, but was denied.

- **Texas** — In conjunction with the Texas Medical Association, the litigation center is supporting two physicians who claim they were fired

without cause and their terminations violate the Americans with Disabilities Act.

- **Tennessee** — The Tennessee Medical Association (TMA) defeated a Tennessee Board of Dentistry (TBD) attempt to allow maxillofacial surgery beyond the statutory mandate. TBD appealed, and the litigation center is aiding TMA's efforts.

- **Wisconsin** — In support of the American Society of Anesthesiologists, the litigation center is consulting on

how to secure just payments in the face of alleged improper bundling and downcoding by Wisconsin Blue Cross/Blue Shield.

The litigation center has filed dozens of amicus briefs in cases ranging from opposing patient care guidelines that do not reflect the generally accepted standard of care in the medical community, to supporting the confidentiality of peer review proceedings in Virginia.



For more information, visit www.ama-assn.org/physlegl/legal/homepage.htm

letter to the editor

PHYSICIAN SUPPORTS practice of certified professional midwives

I was the only physician who spoke in favor of the state permitting the practice of certified professional midwives. I feel the Iowa Department of Public Health should properly regulate the practice via a state-sponsored certification process. It is not a point of Iowa pride for us to be one of only eight states that declare midwifery illegal.

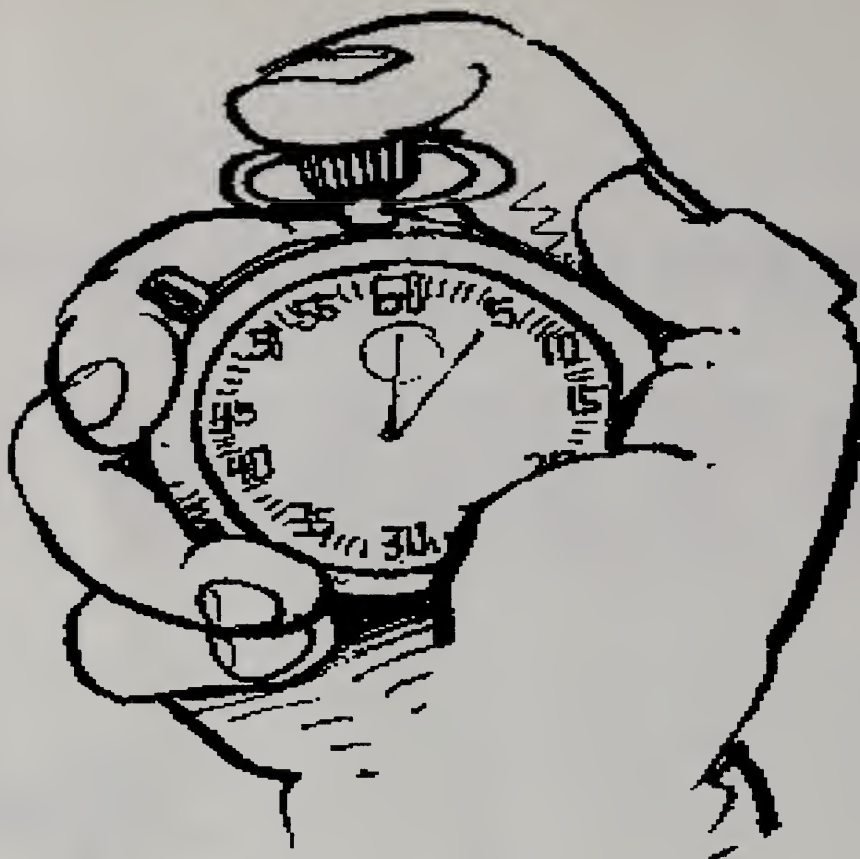
It is predictable that organized medicine opposes this issue. History will show the Iowa Medical Society originally opposed the ability of physician assistants to write prescriptions but eventually changed their opinion. Continued usage of the word "lay" is an obvious attempt to "spin doctor" opinion against the midwife profession.

Medical doctors have historically not supported what they don't understand. Chiropractors, osteopathic physicians, nurse practitioners and acupuncturists have suffered resentment, discrimination and ridicule from organized medicine, even though they have their patients' best interest at heart. Midwives fall in this same category. A majority of physicians have no experience with the midwifery model of care and therefore reject what they do not understand.

Expectant mothers can benefit from residency trained physicians and from competent, attentive and caring midwives. Our patients would be far better served if we worked together for their benefit, rather than each side bitterly despising the other's background and philosophy.

To quote the infamous media figure Rodney King, "Why can't we all just get along?"

— Jon Ahrendsen, MD, Clarion



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IOWA PHYSICIAN distinctions & AWARDS

STEVEN PHILLIPS, MD, was honored by the American Heart Association for his exceptional dedication to research and leadership in the field of cardiac surgery.

PAULA MAHONE, MD, appeared with guest host Bill Cosby on David Letterman's "Late Show."

KATHLEEN HAVERKAMP, MD, received a three-year appointment as cancer liaison physician for the hospital cancer program at Ellsworth Municipal Hospital.

DEAN GESME, JR., MD, was appointed to the CPT Advisory Committee.

RIZWAN SHAH, MD, presented her clinical data on methamphetamine exposed infants and children and the National Institute on Drug Abuse symposium on methamphetamine.

TED HAAS, MD, was

named Physician of the Year at Ottumwa Regional Health Center.

EDWARD FARRAGE, MD, was awarded the 2000 Heritage Award in health and medicine.

NORMA HIRSCH, MD, was honored as the first recipient of the "Women of Influence" award from the *Business Record*.

STEPHEN GLEASON, DO, was appointed to the Council on Scientific and Health Advisors to consider the scientific basis of health policy in Iowa.

FRANCOIS ABBOD, MD, received the 2000 American College of Physicians – American Society of Internal Medicine award for outstanding work in science as related to medicine.

ROBERT KELCH, MD, UICM dean received the IMS Merit Award.

JAMES KIMBALL, MD, received the 2000 IMS Physician Community Service Award for his public service activities in Osceola.

GREG GANSKE, MD, was awarded a special commendation from the IMS for his tireless efforts in the U.S. Congress on behalf of patients' interests and rights.

The following physicians were elected to the 2000-2001 IMS Board of Directors: **STERLING LAAVEG, MD**, president; **HUNTER FUERSTE, MD**, president-

elect; **SIROOS SHIRAZI, MD**, past president; **JOSE ANGEL, MD**, chair; **TOM EVANS, MD**, secretary/ treasurer and district director for district 6. **LEO MILLEMAN, MD**, was elected as at-large director. **TOM THROCKMORTON, MD**, and **JOHN SUTHERLAND, MD**, were elected as speaker and vice speaker of the House of Delegates respectively.

DECEASED MEMBERS

VESNE HEIMANN, MD, 88, life, otolaryngology, Sioux City, January 6, 2000

DAVID THALES, MD, 87, life, family practice, Cedar Rapids, January 30, 2000

RUSSEL VANWETZINGA, MD, 80, life, anesthesiology, Davenport, January 31, 2000

RUSSELL GERARD, II, MD, 82, life, general surgery, Waterloo, March 31, 2000

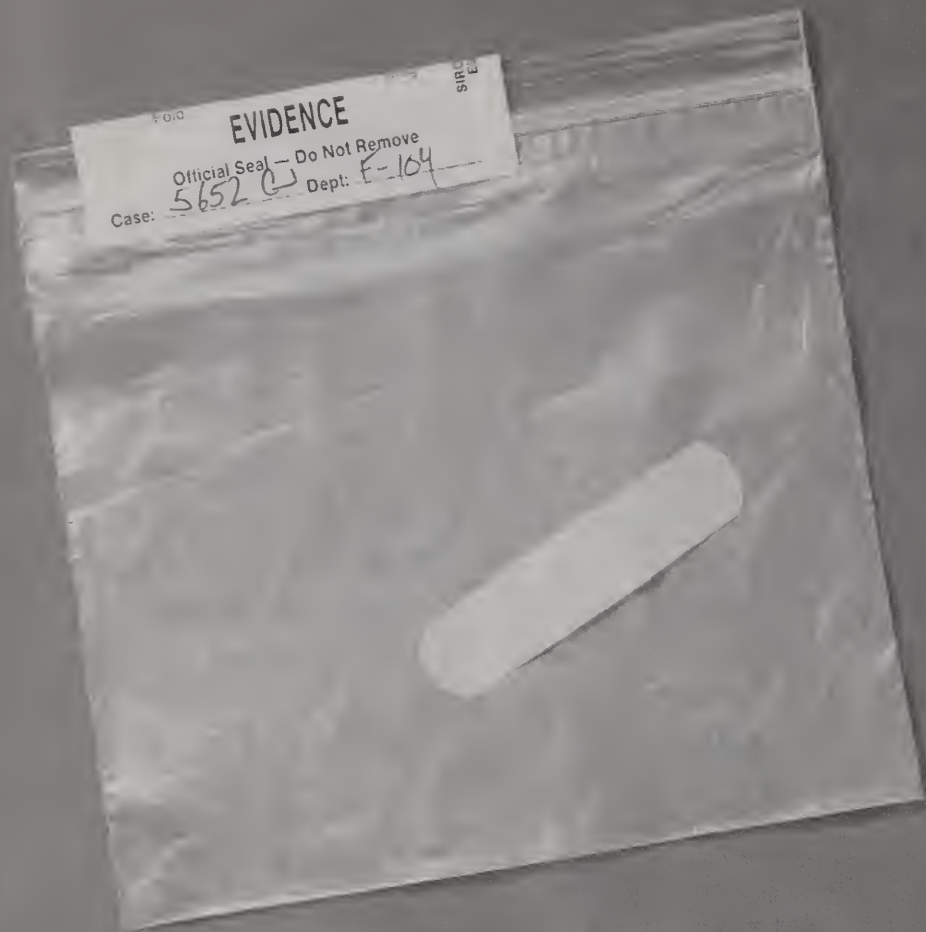
IMS welcomes NEW MEMBERS!

Michael Giordano, MD, Waterloo
Annie Kontos, DO, Waterloo
Dan Mulholland, MD, Waterloo
John Musgrave, MD, Waterloo
Mark Wertheimer, MD, Dubuque
Jennifer Maxwell, MD, Cedar Rapids
Gary Schweiger, MD, Cedar Rapids
David Wright, DO, Denison
Anita Eshelman-Peters, MD, Lake Mills
Orville Jacobs, DO, Marshalltown
L. K. Berryhill, MD, Fort Dodge
Robert Wisco, MD, Sioux City
Sharon Hale, DO, Clarion

Paul Thomas, DO, Eagle Grove
Kevan Zechin, Sr., MD, Clarion
Kumar Kadiyala, MD, Iowa City
Michael Winniford, MD, Iowa City
Mona Al-Qulali, MD, Clinton
Luis Barrios, MD, Clinton
Sukhdarshan Bedi, MD, Burlington
Reed Bouchey, MD, Mt. Pleasant
Djonggi Situmeang, MD, Mt. Pleasant
Xiaolu Li, MD, Keokuk
Arthur Mardis, MD, Keokuk
Kenton Hall, MD, Davenport
Retta Pelsang, MD, Davenport

David Spector, MD, Davenport
Narendra Batra, MD, Centerville
Shawn Richmond, MD, Oskaloosa
Laura Griffith, DO, Knoxville
Matthew Caterine, MD, Des Moines
Julia Goodin, MD, Des Moines
Rodion Herrera, DO, Des Moines
David Lacey, MD, Des Moines
Fred Margolin, DO, Des Moines
Mark Shaw, MD, Des Moines
Jeffrey Watters, MD, Des Moines

Members of the Iowa Medical Society join in welcoming the following new members into a progressive state medical association. The core purpose of the IMS is to assure the highest quality of health care in Iowa through our role as physician and patient advocate. Each new member is encouraged to join other IMS members at both local and state levels in achieving these goals.



*e*xhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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EMTALA — Are you at risk for violations?

You make decisions every day about patient care. Sometimes those decisions involve whether to transfer a patient to another facility, or send them out for a diagnostic procedure. Whatever the reason for the transfer, complying with the federal law known as “EMTALA” is mandatory.

The Emergency Medical Treatment and Active Labor Act (EMTALA), was passed as part of the Comprehensive Omnibus Budget Reconciliation Act of 1986. It is also called the “COBRA” law or the “anti-dumping” law. The original intent was to prevent hospitals and physicians from rejecting emergency patients who were unable to pay for their care.

Under the law, an appropriate medical screening examination must be given to all patients on the hospital property to determine whether an emergency medical condition exists prior to any transfer. This includes patients going off-site for

diagnostic testing and returning to the facility. Any emergency medical condition must be stabilized before transfer to another facility; for actively laboring patients stabilization is defined as delivery of the infant and placenta.

There may be substantial penalties if EMTALA regulations have been violated. Hospitals and physicians face fines of up to \$50,000 per violation and possible termination from Medicare Fines and penalties are typically

excluded from any type of insurance coverage.

Risk Management tips:

- Know your facility’s policies regarding your on-call responsibility.
- Understand your facility’s policies on transfers.
- Be aware of your responsibility to stabilize a patient before transfer.
- Consider the benefit transfer has to the patient, against the risk of transfer.



how we learn

The choice of SPECIALTY

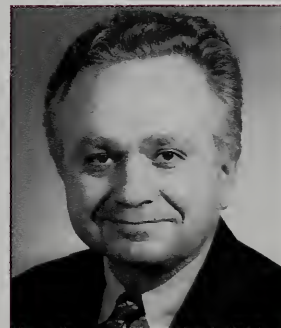
The Ides of March now bring an annual ritual to medical education: the match of the graduating medical student to a specific residency training program. Each year about 16,500 students soon to receive the MD degree (and additional students who have received an osteopathic education) vie for their preferred programs.

This year has been no exception. At the University of Iowa, the interest of graduating students in the primary care specialties remains

strong. The choice of anesthesia is on the rebound. Surgical specialties are very competitive, while a few disciplines (notably, psychiatry) are not fully subscribed.

Despite ongoing national surveys and studies, the reasons for student choice of specialty are not simply explained. Mentors, skills, temperament and the marketplace each play a role.

Ultimately, the number and distribution of specialists reflects a balance of individual choice and the opportunity to practice.



This column is provided by Midwest Medical Insurance Company especially for Iowa physicians. For more information, call Lori Atkinson, MMIC risk management manager, at (800) 798-9870 or (515) 223-1482.

This column is written by Dr. Richard Nelson, executive associate dean, University of Iowa College of Medicine.



SURGERY? Put it out to bid

First you could name what you'd be willing to pay for an airline ticket on *priceline.com*. Now, bidding has made its way into the health care world.

It's being made possible by medical Web sites, including

Webhealthy.com, which debuted March 29, 2000.

Here's how it works: On the Web site, medical providers post services they offer and what they charge. Patients wanting to cut the price can make an on-line bid. From there, patient and physician negotiate.

While many of the services on the *Webhealthy.com* site are free, the company hopes to make money by charging a

subscription fee for people wanting unlimited access to its services.

A growing number of on-line services are allowing people to negotiate directly with physicians. Other sites include *Medicineonline.com* and *Healthallies.com*, both California firms.

Webhealthy will have to work hard early on to turn a novel idea into profits, industry experts predict.

Web site helps physicians locate free meds for low-income patients

Volunteers in Health Care has created a one-of-a-kind, free resource for physicians trying to obtain prescription medications for their low-income patients. The service is a searchable Web database, called RxAssist, which helps physicians and health care providers locate, choose and learn how to apply for free or discounted medications made available through pharmaceutical manufacturer patient assistance programs.

Found online at *www.rxassist.org*, RxAssist contains up-to-date information on how to access nearly 100 pharmaceutical company patient assistance programs.

RxAssist provides the ability to search for a program by company name, generic drug name, brand name or drug class; a list of all drugs or programs that meet the physician's search criteria; the latest information on application procedures for each program, summarized in easy-to-follow steps; a list of documentation required to apply; tips and comments sent in by fellow health care providers and nearly 30 program application forms, which users can download and complete.

RxAssist is a service of Volunteers in Health Care, a national resource center for volunteer-supported health care programs, which is funded by the Robert Wood Johnson Foundation.

PHYSICIAN STATS? Just a click away...

Patients in New York can look on the Web to see how much experience physicians have in surgical procedures.

The information, compiled by medical consumer groups, includes data from physicians at 260 hospitals across the state and is available at *www.medicalconsumers.org*.

But some experts are skept-

ical about how meaningful the information is since it gives consumers only a snapshot of how their hospitals and physicians are doing.

Watch for information on Iowa physicians at *iowadocs.com*, a Web site dedicated to giving Iowa patients the correct information on Iowa physicians.

UI Health Care has partnered with *AmericasDoctor.com* to follow the increasing trend in health care toward enhancing consumer services through the Internet. According to recent statistics compiled by Cyber Dialogue, a New York firm that tracks Internet commerce, there are approximately 22 million Web users seeking health information over the Internet. Cyber Dialogue projects that number to increase to 33 million over the next year.

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THE RIGHT to UNITE

Physicians can't be effective patient advocates unless they can negotiate over contract provisions.

Excerpted with permission from the April 17, 2000 issue of the *Des Moines Business Record*

by Jeanne Lightly

Orthopedic surgeon Sterling Laaveg sees patients every day at the Mason City Clinic where he works. He calls them by name, and even knows how many kids they have. He's their friend and advocate. He worries about them receiving inadequate insurance coverage. That's why he's lobbying, writing letters and meeting with congressmen about H.R. 1304,

the Quality Health Care Coalition Act of 1999, sponsored by Rep. Tom Campbell, R. CA. The bill would exempt doctors from antitrust lawsuits.

Laaveg says the landmark legislation would level the playing field between health plans and physicians. The bill, known as the Campbell

“
Physicians will be one step closer to fixing a system that allows insurers virtually unlimited power over health care.”

Bill, passed the House Judiciary Committee by an overwhelming vote of 26-2 on March 30. Iowa Reps. Ganske, Leach and Boswell support the bill.

“The legislation would allow physicians to come together and negotiate with health plan providers over contract provisions, so they can fulfill their role as patient advocates,” Laaveg says.

If the bill passes, Laaveg says physicians will be one step closer to “fixing a system that allows insurers virtually unlimited power” over health care.

“The role of physician as advocate can easily be undermined when he or she has no leverage in the face of a large, controlling health plan.”

POWER OF THE INSURER

According to Mike Abrams, executive vice president of the Iowa Medical Society (IMS), most physicians are independent contractors. Under current guidelines, doctors must be in business together in order to negotiate jointly with a health plan.

"Forming, managing and operating networks or group practices is a very expensive and time consuming undertaking," Abrams says. "Physicians are understandably reluctant to do this because it requires substantial capital, forces them to practice in a setting they may not prefer and may not even provide antitrust protection because the guidelines are not entirely clear."

Supporters of the Campbell bill say it provides a counterbalance to the growing power of insurers as they merge into enormous bureaucracies. According to Ed Brown, CEO of the Iowa Clinic at Iowa Methodist Medical Center, Wellmark Blue Cross and Blue Shield has 42 percent of the Iowa market so there is not a lot of choice. He says six big insurers monopolize the market.

In Manhattan, a lawsuit was filed against Metropolitan Life Insurance and United HealthCare Corp that claimed the two companies used flawed and invalid data

to reduce payments for medical services.

"This is one example of insurance companies playing by their own rules without regard to patients or the legitimate costs required to care for them," says American Medical Association Trustee Donald Palmisano. "Unfortunately, there is no reason to believe this is an isolated situation. In fact, the circumstances suggest that this practice is widespread."

THE COST OF CARE

Opponents say the bill would increase costs to the consumer. Groups such as the U.S. Chamber of Commerce, the American Hospital Association and the National Association of Manufacturers say the bill would permit physicians to engage in anti-competitive practices such as price-fixing, boycotts and market allocation agreements.

Says Karen Ignani, president of the American Association of Health Plans, "Consumers and employers will

shoulder the burden of higher costs, decreased access, less choice and lower-quality health care."

Officials at the Iowa Medical Society dispute these claims. "What I have learned is that any time someone wants to kill a bill, they raise the issue of cost," Abrams says. "But there is no substantial proof the bill will raise health care costs."

A Penn State University study shows when the benefits to society are weighed against potential costs, H.R. 1304 may cost nothing at all. The study found that an earlier insurance-sponsored study used "questionable assumptions" and relied heavily on opinion, not empirical evidence.

If costs should increase significantly, according to Palmisano, Congress is free to reevaluate. He predicts the bill will give power back to the patient at little or no cost to society.

UNDERCUTTING THE LAW

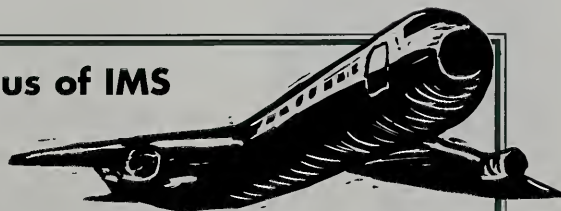
Ignani says the bill serious-

“
An earlier insurance-sponsored study used ‘questionable assumptions’ and relied heavily on opinion, not empirical evidence.
”

Campbell Bill will be focus of IMS Washington, DC fly-in

The Campbell Bill and the Patient Bill of Rights will be the focus when

IMS officials travel to Washington, DC May 8 and 9. Participating in the fly-in will be Dr. Sterling Laaveg, IMS president; Dr. Amir Arbisser; Mike Abrams and Jennifer Davis, IMS manager of legislative affairs. The group will visit offices of Iowa congressmen to discuss key issues for Iowa's physicians and patients.



ly undercuts antitrust laws. "Under the Campbell Bill, physicians would be accorded special interests. They would be accorded special protections unavailable to any other workers."

The Federal Trade Commission has taken action against physician groups for refusing to contract with health plans or engaging in price fixing.

"This bill will only encourage these practices and take away the government's ability to stop them," Ignani says.

In contrast, Jeanine Freeman, IMS vice president of public policy and advocacy, says the bill will not compromise the ethical and legal duties of doctors since it does not allow them to strike.

"It's not about price-fixing

or setting fees," she says.

"Doctors are very concerned about the effect of 'take it or leave it' contract terms and conditions on their ability to provide high quality care." (See box.)

A VICTORY FOR DOCTORS

Physicians are beginning to make headway. Washington state's antitrust waiver legislation for physicians, implemented in 1995, has allowed more than 4,000 private physicians to negotiate jointly with a statewide Wellmark health plan last summer. They changed seven contract provisions to their satisfaction, according to John Arveson, director of professional affairs of the Washington State Medical Association.

Texas legislation that falls under State Action Doctrine went into effect September 1, prompting a group of 60 San Antonio orthopedic surgeons to apply to the state attorney general to enter into contract negotiations with several major health plans over fee and non-fee-related provisions. The Texas attorney general rejected the application last October, since it did not meet application rules. In the amended filing, the physicians must include an index to all health plans they have contracted for the past three years and detail how the requested negotiations will help patients.

POOL NEGOTIATING

The State Action Doctrine allows states to pass legislation that is prohibited by antitrust laws in the state only. The Campbell Bill would permit pool negotiations regardless of location, while allowing independently practicing doctors to jointly negotiate with health plans by amending federal antitrust laws.

Meanwhile, Laaveg's patients remain his motivation for lobbying, writing letters and making phone calls to Congress. He's betting on victory. Then, he says, his patients will have more insurance options. And he can rest.

Take it or leave it, doctor

Jeanine Freeman, vice president of public policy and advocacy for the Iowa Medical Society, says physicians are concerned about 'take it or leave it' contract provisions and their effect on the quality of health care provided to Iowans. She lists the following flaws in the system:

- Prohibiting doctors from discussing all treatment options with their patients;
- Restrictions on access to specialists;
- Payment schemes that encourage limitations of medically necessary care;
- Dumping doctors from a plan without cause;
- Requirements that doctors must participate in all of the insurers' plans or none.



Don't let UNCERTAINTY drive *your decisions*

The financial decisions you make now could change the future for your children.

by Jerry Foster

In order to better serve its clients, Foster Capital Management has tried to establish an understanding of the financial and estate planning strengths of Iowa physicians in order to better serve.

FINANCIALLY ASTUTE

Physicians tend to be financially astute, but personal and work constraints limit the time dedicated to financial matters.

STRONG FUTURE

Physicians have created a strong financial foundation or are on their way to establishing such a foundation.

SOCIAL LEADERS

Physicians tend to be civic or social leaders and have had a significant impact on their patients and community.

In the midst of developing those strengths, several concerns begin to cloud the horizon of financial planning, and there is a constant state of confusion and complexity. With so many options and conflicting information, choices can be overwhelming when the stakes are high. Uncertainty and fear can dominate thinking and drive people to make decisions that may have negative long-term consequences.

It seems no matter how much money people have accumulated, nagging questions will make them wonder if they have done enough. "Will I really be able to meet my goals, and what are the consequences if the unexpected happens?"

CARING

Physicians have spent their entire careers helping others, and that driving need to have a sense of purpose and significance continues to push them. Eventually, the question becomes larger in scope as we all begin to ask ourselves about the legacy we will leave. "Who am I really affecting, and what will I be remembered for?"

True financial planning cannot ignore the significance of these concerns. Integrating your current financial situation with fears and concerns about the future, as well as understanding the effect that your financial and personal decisions have on the big picture, is truly what comprehensive planning is all about.

Planning in this way should ultimately provide clarity, peace of mind and a sense of purpose and fulfillment.



Jerry Foster is the CEO of Foster Capital Management, a fee-only financial planning and investment management company located at IMS headquarters, (800) 798-1012.

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Feedback on BME

Editor's Note: The January-February issue of Iowa Medicine carried a feature story about chronic problems plaguing the Iowa Board of Medical Examiners. IMS leaders and staff continue working with the BME on licensing and renewal issues. In a special reader viewpoint, Steve Harlan, MD, a Des Moines dermatologist, offers the following recommendations for solving the BME's problems. In the box, Ann Mowery, executive director of the BME, reports to Iowa Dept. of Public Health Director Dr. Stephen Gleason on progress made toward reducing the license and compliance backlog.

A crisis of the magnitude of the one faced by the Iowa Board of Medical Examiners will inevitably cause a paradigm shift. I believe that when waste and inefficiency have been addressed, the physicians of Iowa will approve paying for the changes in license fees.

The solutions to fix the problem are straightforward:

1. Prosecutors from the office of the attorney general should not sit at meetings of the IMBE providing the routine legal advice and guidance to the Board members.

2. The IBME should be a panel of judges. They should not micro-manage or be

afraid of making a legal mistake. We need physicians on the BME who have a sense of what's appropriate and what's not appropriate and the courage to insist on it.

3. For legal advice, the BME needs an independent attorney who is not involved with prosecution.

4. A full-time physician medical director is needed for the BME. This will help alleviate the 10 pounds of paper which is required reading before every board meeting. Every complaint can be investigated, those without merit can be closed and the dangerous doctors followed up on immediately. Insurance companies use physicians as

medical directors but still maintain control.

5. Establish written professional guidelines of training and conduct for investigators. The rules should be available for everyone.

6. Clear the 12-year backlog of investigations and start with a clean slate. Provide written warnings where appropriate. If the physician disregards a warning, consequences will be swift.

The goal is to get intelligent people who have dedicated their lives to patient care to improve themselves.

Steven Harlan, MD

Iowa Medicine
January/February 2000 An Iowa Medical Society publication

Ready, set . . . WAIT
Physician licensure in Iowa — page 18

IMS to join Medicare lawsuit / page 9
Antibiotic resistance is a critical issue here / page 12
Place your nominations for IMS offices / page 16
AMA launches National House Call / page 25

Yes, Iowa physicians watch EMT (special insert)

15 Years OF CARING FOR IOWANS

Update from the Board of Medical Examiners

Licensure

Our goal to license all uncomplicated applications has been reached with two or three temporary positions. We are quickly reviewing all the new applications for obvious missing components. First reviews are being done at 60 days (they were at 90+ days). I expect the timeframe for first reviews to get to 45 days once our new full time employees are hired.

Compliance

Our goal for the year is to act on 700 mal-practice cases. We expect to hire a chief investigator and medical consultant after the Legislature approves the budget. The Board has reviewed 216 pre-1990 mal-practice cases. The Board closed 151 with no action and requested further information on the remaining cases. The staff is now obtaining the physicians' responses and pertinent medical records.

Media violence = **REAL** violence?

In Kentucky, a 14-year-old boy fired eight shots on fellow students. Though he had never before used a

handgun, he fired eight times and hit eight students. After playing "Doom," a video game where players win points by shooting guns and killing the enemy, for hours, he had perfected his aim.

Media violence was one of the topics at the AMA National

Leadership Development Conference. Lt. Col. Dave Grossman addressed this issue and its impact on children across America. He is the author of "Stop Teaching Our Kids to Kill: A Call to Action Against TV, Movie and Video Game Violence." What makes our children commit such horrifying acts of murder? Why have our children become desensitized to these violent acts?

Following the Columbine High School shootings, CBS President Leslie Moonves said, "Anyone who thinks the media had nothing to do with it is an idiot." Media executive Ted Turner recently stated, "Television violence is the single most significant

factor contributing to violence in America." Top executives of the television industry, like Mr. Turner, have the power to stop the violence and crime their networks are producing, yet they choose financial gain over loss of life.

Why have our children become desensitized to violent crimes? We can begin by pointing our finger at the makers of video games, TV networks and those who produce entertainment for the movie industry.

In conjunction with the

anniversary of the Columbine shootings, the AMA Alliance with state Alliances nationwide challenged all to participate in National Turn Off the TV week April 24-30, 2000.

We as parents, grandparents, physicians and spouses, need to monitor the programs our children watch and the video games they play. Let's make this a routine, not just a one week per year event. Only then can we begin to change the behavior and attitudes of our youth towards violence.



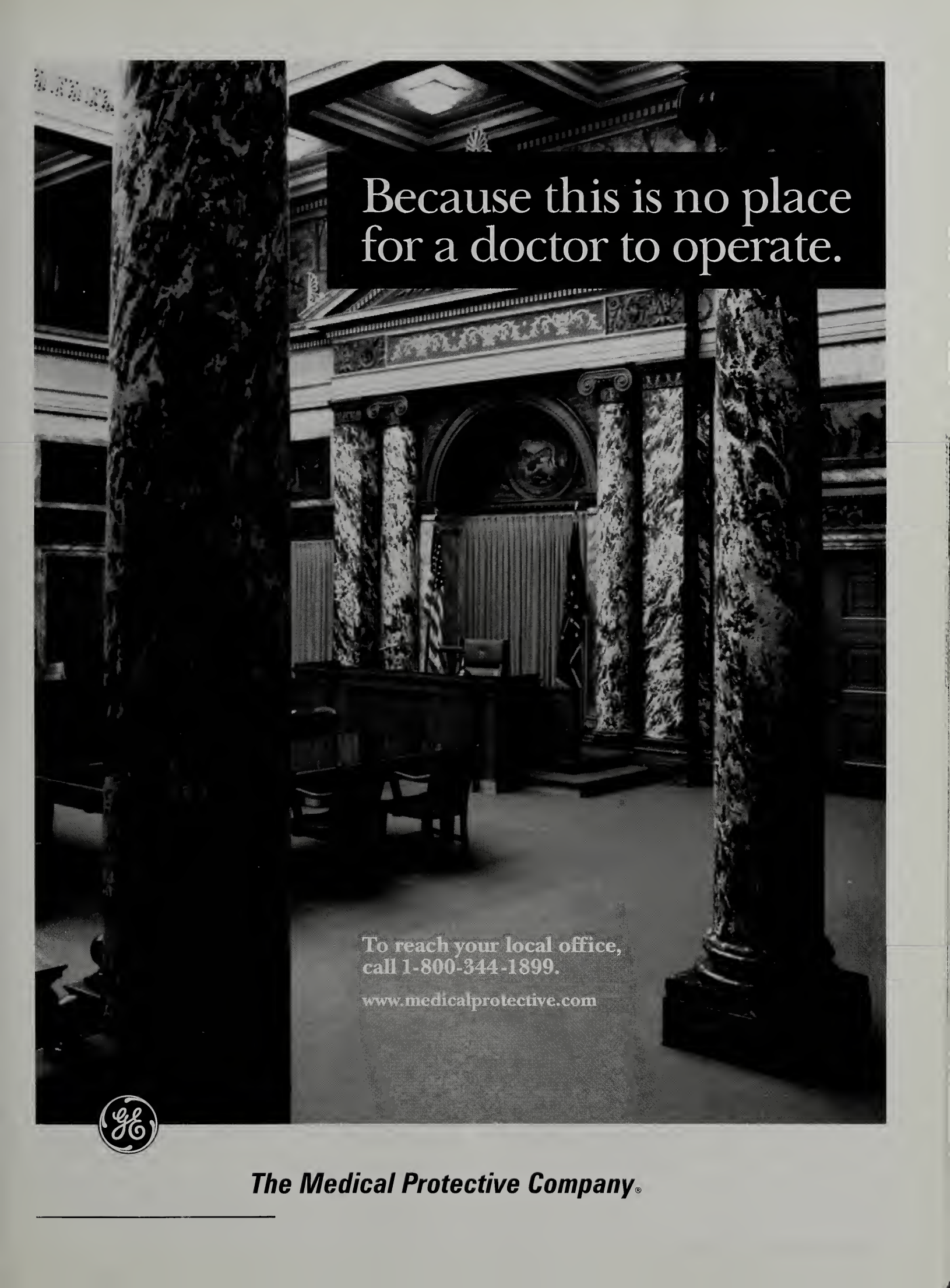
This article was written by Ann Crouch, IMSA president.

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Physician's Source

Vol. 1 Issue 1

Spring 2000

Methamphetamine Prevention: Before The Abuse And Addiction

Fact: Methamphetamine is a part of the Iowa landscape, affecting every walk of life.

Question: What can we do as physicians to help combat it?

If necessity is the mother of invention, then the increasing number of medical traumas and deteriorating health seen in patients due to the abuse of methamphetamine has lead the Iowa Health System to take a look at developing a proactive approach to the problem – education and intervention. In an effort to help arm physicians, PAs, nurses, and others with the tools necessary to engage in the fight against substance abuse, this quarterly newsletter, coupled with the development of physician seminars, physician and patient brochures, and a highly in-depth web site have been developed.

In this premiere issue, we focus on methamphetamine: what it is; what are the warning signs, short- and long-term physiological and psychological effects; and where more information and treatment facilities can be found. Future editions will contain updates on the

latest medical issues surrounding drug abuse and will profile other illicit substances. Availability of additional educational materials will be forthcoming.

We hope that, through continuous education, we can effectively approach and inform our patients about the perils of abuse, intervene when use is suspected, and prevent addiction before it begins.

What's Inside?

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Methamphetamine?
page 2

Fast Facts About Meth
page 2

Immediate Effects
Of Meth Abuse
page 3

Long-Term Damage
From Meth
page 3

Question: What can
we do as physicians
to help combat
methamphetamine?

Fact: Meth
is a part of
the Iowa
landscape,
affecting
every walk
of life.

Frontline Facts

- In 1998, 320 meth labs or dumpsites were found in Iowa, up from 63 in 1997 or an increase of over 500%. As of April 1999, authorities had already uncovered 170 labs or dumpsites.
- Over 85% of methamphetamine in Iowa is smuggled from California and Mexico into the state.
- 5% of users will have permanent delusional disorders (flashbacks) with paranoia.
- The federal authorities have identified Iowa as one of five states with a "high intensity" meth area. Other states include: Nebraska, Kansas, Missouri, and South Dakota.
- *The Des Moines Register* reports that, according to their electronic archives, there were only 35 methamphetamine references in the newspaper in 1991. In 1999, (through June 24), there were 369 references.
- According to Janet Zwick, division director of the governor's substance abuse alliance, in 1998 more than 3,721 people in Iowa sought help for methamphetamine addiction, up 18% from 1997.

What Is Methamphetamine?

Methamphetamine (meth) is an intense psychostimulant with strong effects on the central nervous system. Developed from the parent drug, amphetamine, meth was originally used in nasal decongestants and bronchial inhalers before it was classified as a Scheduled II stimulant, which indicates that it has a high potential for abuse and is only available in prescriptions that cannot be refilled.

Odorless and bitter tasting, meth is ingested orally (pills/tablets/capsules), injected or snorted (powder), or taken intravenously (dissolved in water or alcohol). Meth is also “cooked” and sold in various forms. “Ice,” a smokable form of crystalline methamphetamine, has a higher level of purity (around 97%) and looks like chipped ice, rock salt or chipped glass. Ice is smoked in a hand-sized glass pipe and the residue remains in the pipe where it can be smoked again. Crystallized meth or “crystal meth” (powder) has varying degrees of purity and can be smoked, injected, snorted, or ingested orally. Generally clear in composition, crystal meth may also be milky white or yellowish brown.

Euphoric effects from meth begin within 30 seconds by injection, three to five minutes through snorting, or 15 to 20 minutes if swallowed. The high for crystal meth will last two to four hours and seven to 24 hours for the high from ice.

Meth is made easily in covert laboratories with relatively inexpensive over-the-counter ingredients. Key components include: anhydrous ammonia (fertilizer, refrigerant), hydrochloric acid (drain opener), and ether (starting fluid cans).

Meth continues to be used as a prescribed drug in limited use under the name Desoxyn, which is used to treat obesity and hyperactivity/attention deficit disorder in children.

Warning Signs

Common indications that a patient may be using methamphetamine include:

- excessive activity, talkativeness, irritability, argumentative, or nervousness
- increased blood pressure or pulse rate, dilated pupils
- long periods without eating or sleeping
- euphoria

Methamphetamine: Common Street Names

meth, speed, crank, blue, blue cheer, croak, crypto, ice, white cross, crystal, glass, fire

(injecting and smoking) in which the drug is taken.

The binge phase is sub-divided into the following categories:

- **Rush:** 5-30 minutes – heartbeat races, metabolism, blood pressure and pulse soar, feelings of pleasure are felt;
- **High:** 4-16 hours – user feels aggressively smarter and becomes argumentative;
- **Binge:** 3-15 days – user maintains the high for as long as possible, becomes mentally and physically hyperactive;
- **Tweaking:** the most dangerous stage of the cycle;
- **Crash:** 1-3 days – user does not pose threat to anyone and becomes almost lifeless and sleeps;
- **Normal:** 2-14 days – user returns to a state that is slightly deteriorated from the normal state before the abuse;
- **Withdrawal:** 30-90 days – no immediate symptoms are evident, but the abuser becomes depressed and then lethargic. The cravings for meth hits can cause the user to become suicidal. A high percentage of addicts return to abuse in order to eliminate these negative feelings.

Tweaking is the result of an abuser who has not slept in three to 15 days, is irritable, and has reached a state of extreme paranoia. Tweakers have extremely unpredictable behavior and a tendency toward violence due to their delusional mental state. Although a tweaker can appear to be “normal,” (clear eyes, and normal speech and movement), a closer examination will reveal that the eyes are moving ten times faster than normal, a quiver exists in the voice, and movements are quick and jerky.

High-intensity users, or “speed freaks,” focus on preventing the “crash.” The pattern does not usually include a state of normalcy or withdrawal. High-intensity abusers experience extreme weight loss, vary pale facial skin, sweating, body odor, discolored teeth, scars and/or open sores on their body. The scars are the results of hallucinations of bugs on the skin, called formication.

Patterns Of Abuse

There are three stages of methamphetamine abuse. Those stages have been identified as low-intensity, binge, and high-intensity. In the low-intensity phase, the abuser does not become psychologically addicted. Bingeing and high-intensity abuse differ based on the frequency and form

The Effects Of Meth

Meth is extremely addictive, even after one use, and is believed to be more psychotic than cocaine. Traveling in the bloodstream to the brain, methamphetamine stimulates excessive release of the neurotransmitter dopamine into areas of the brain that regulate feelings of pleasure and addiction. This chemical reaction causes the user to feel boundlessly energetic and have perceived elevated powers of thinking. Meth also appears to have a neurotoxic effect, damaging the brain cells that contain dopamine and serotonin. Meth, over a long period of time, also seems to reduce the levels of dopamine, resulting in symptoms similar to Parkinson's disease.

Physical Effects Of Meth

- increased heart rate and blood pressure
- blurred vision
- stomach disorders
- increased wakefulness, insomnia
- hyperactivity, increased physical activity

Psychological Effects Of Meth

- hallucinations (auditory and visual)
- severe anxiety
- memory loss
- paranoid psychosis, which can lead to homicidal and suicidal thoughts
- deep depression
- aggressiveness, combative or violent behavior
- irritability, confusion
- delusions and formication (the sensation of insects creeping on the skin)

- decreased appetite, weight loss, extreme anorexia
- respiratory problems
- hypothermia
- convulsions, tremors
- cardiovascular problems, cardiac arrhythmia
- irreversible damage to blood vessels in the brain, producing strokes
- damage to the brain, lungs, and liver

Immediate effects from use include: euphoria, enhanced wakefulness, increased

physical activity, and decreased appetite. Long-term effects include violent behavior, anxiety, confusion, and insomnia. Chronic use can quickly deteriorate the health of the user and cause irreversible damage, both physically and psychologically. Health problems resulting from long-term use are highlighted in the boxes above.

Resources

For information on treatment facilities in your area, call the Iowa Substance Abuse Information Center in Cedar Rapids at **800-247-0614** or visit the following web site and click on the directory of services:

<http://isaic.cedar-rapids.lib.ia.us>

For more information on methamphetamine and other substances of abuse, visit our web site at **www.PhysiciansSource.com**. If you have a specific questions or case and would like to consult with another physician directly, please contact Dr. Dennis Wies, M.D., FASAM, at **515-263-2424**.

An Ongoing Rolodex



Every quarter, we will provide contact information for additional agency resources. Retaining this information will allow you to access a wealth of information with just a few phone calls.

Governor's Alliance On Substance Abuse

515-281-4518

Iowa Crime Prevention Association

515-334-8790

Iowa Department Of Public Health

515-281-4404

Alcohol And Drug Dependency Services Of Southeast Iowa, Burlington

319-753-6567

What's Inside...

Patterns Of Abuse

What are the cycles of abuse for methamphetamine? What does tweaking mean? Learn more about the patterns of abuse and the telltale signs of addiction.

Frontline Facts

Noteworthy news and statewide statistics present an eye-opening look into the methamphetamine problem in Iowa.

Effects Of Meth

Methamphetamine is extremely addictive, even after one use. But what are the immediate effects? What effects does the drug have on the brain and central nervous system? The long-term psychological and physical risks associated are spelled out within.



IOWA HEALTH
SYSTEM

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Working for Iowa physicians and their patients

Joining THE FIGHT

In fall 1997, the IMS Committee on Public Health identified physician education on methamphetamine as one of its top public health concerns.

With this issue of *Iowa Medicine*, you will find a very special newsletter, sponsored in part by IMS, called **Physician's Source**. The newsletter is part of a physician methamphetamine education program created and implemented by Iowa Health System, the Iowa Department of Public Health and the Governor's Alliance on Substance Abuse.

"We wanted to do something to help," says Barry Spear, vice president for system development for Iowa Health System. "The Iowa Department of Public Health and the Governor's Alliance both said that what is needed is a coordinated physician education program."

The program includes brochures for kids and parents, posters, a 'train-the-trainer' video and lab coat cards listing observable signs of methamphetamine use. Information is also available on the legal aspects of intervening with adults and children who are using methamphetamines.

The program includes a methamphetamine education web site for physicians, www.PhysiciansSource.com.

Iowa physician groups involved in the program include the Iowa Academy of Family Physicians, Tri-Mark,

Grandview, Integra and Trinity Health Partners.

Any physician who has a specific question or case and would like to consult directly with another physician, please contact Dennis Weis, MD at (515) 263-2424.

Methamphetamine web site:
www.PhysiciansSource.com

healthy iowans

Don't miss this OPPORTUNITY

Many changes have taken place in the management of diabetes in the past several years. "Improving Your Diabetes IQ" will present a series of six one-hour programs over the Iowa Communications Network (ICN) to bring you the latest in diabetes care. Experts in diabetes will discuss new therapies, drugs, standards of care, clinical practice guidelines and much more. You may invite key members of your diabetes treatment staff to attend WITH you!

Participants will receive both six hours of Category I continuing medical education and a personalized press

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**SIX ONE-HOUR PROGRAMS
OVER THE ICN**

Bring back the

HUMANISM



Physicians need to remember their most valued mentors and do the best for their patients.

by Donald Moorman, MD

Did you know 48 percent of health care dollars are expended solely for administration of managed care plans? We are told our patients need advocates and care planners to assist their recovery. When did physicians become inefficient in advocacy for our patients?

I recently received a letter that listed information to determine if I am a good physician. I was told the quality of my care can be determined by the parameters collected and analyzed by both our corporate structure and our provider panels. My quality is measurable by the length of my patients'

stay in the hospital, the cost of their care and the rate of associated inflicted morbidities resulting from their therapies.

Additionally, it seems medical educators have become ineffective in determining the characteristics essential in young physicians. I sign applications to specialty boards with the best interest of the public. I consider this only a minimum standard of competence and "quality." Much greater is the personal and intimate knowledge of their capability that only the faculty possess.

The National Labor Relations Board recently decided resident physicians are no longer students; they are employees. They can unionize, bargain and be expectant of all the rights accorded by regulations that provide protection for much less savvy laborers. Even more concerning to me, the American Medical Association recently realized I am also an employ-


ee. I always thought I was a professional member of our health care team, providing professional insight into my patients' maladies and keeping a caring professional relationship with them all.

We have lost some of the humanism essential to our profession. Physicians of the past, prior to modern drugs and technology, often relied on their ability to touch a hand and ease a fear. No one questioned their ability to provide quality care. No one seemed concerned about abuses of their health care dollars. Physicians likely did not have a purpose to collectively bargain. Clearly, we may wish to reflect on this in our professional lives. I hope I will not be reduced to working a shift and carrying a union card with no personal knowledge of those for whom I care. As technologies advance, let us strive to retain essential humanism as the foundation of our professional actions.

“ We have lost some of the humanism essential to our profession...

We may wish to reflect on this in our professional lives... ”

Dr. Moorman is a general surgeon with the Iowa Clinic in Des Moines and a member of the Iowa Medical Society.



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IOWA MEDICAL SOCIETY

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The cards have been dealt... TOBACCO dollars DECIDED



The IMS Committee on Public Health, through its subcommittee on tobacco, developed recommendations to guide the policy debate on how best to spend Iowa's share of the tobacco settlement funds. The General Assembly and Governor agreed with IMS that tobacco monies must be dedicated to health care purposes, including a comprehensive tobacco use, prevention and control program funded at CDC levels and dollars to raise Medicaid reimbursement to Iowa Medicare levels.

Remaining dollars at the end of the fiscal year will revert to the settlement fund, not the general fund.

Separate legislation establishes a tobacco use, prevention and control commission and creates a tobacco settlement authority to secure the tobacco monies through a bonding process.

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<i>Adoption/independent living/shelter care</i>	500,000
<i>Hospitals</i>	2,300,000
<i>Home health</i>	2,400,000
<i>Critical access hospitals</i>	250,000
<i>Home health for children with special needs</i>	4,400,000
<i>Respite services/waiver programs</i>	1,200,000
<i>Human service provides</i>	500,000

HAWK-I (200 percent of federal poverty)200,000

CONTINUOUS ELIGIBILITY UNDER MEDICAID

(2-county pilot program)35,000

SUBSTANCE ABUSE TREATMENT11,900,000

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<i>Leading cause of death preventative strategies</i>	163,000

DEPARTMENT OF CORRECTIONS

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TOBACCO USE, PREVENTION AND CONTROL9,345,394

Includes state and local efforts

Monies to be leveraged with dollars from other programs

FTEs...7.00

Within the Iowa Department of Public Health

Statewide youth summit on tobacco use and prevention

by August 15, 2000

MENTAL HEALTH/MENTAL RETARDATION/DEVELOPMENT

DISABILITIES (local services funds)2,000,000

SAVINGS ACCOUNT FOR HEALTHY IOWANS3,800,000

IMS CELEBRATES 150 at annual meeting

Three amigos — (left) Dr. John Brinkman, immediate past president; Dr. Sterling Laaveg, president-elect; and Dr. Siroos Shirazi, president, pose at the Iowa Medical Society's 150th birthday party Saturday April 15.



Josh Rosebrook, M3, introduces and welcomes Ryan Tripp during the IMS Education Session.

Dr. Lee Fagre (center), chair of the 2000 IMS Program Committee, with the panel for the IMS Education Session presentation "Teenage Heroes and Role Models." With Dr. Fagre are (left) Rashad Williams, Alison Mostrom, Ryan Tripp and Jennifer Lillis.



The Maple Street Baptist Church Choir sang before the Sunday House of Delegates session.

Dr. Beck Weathers (left), the Texas physician who nearly died during a 1996 climb of Mt. Everest, greets AMA Past President Dr. Nancy Dickey after Saturday's 'Into Thin Air' luncheon. Nearly 300 people came to hear Dr. Weathers speak.

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grams at the DOC's 700-bed intake facility at
Oakdale, Iowa, which includes a 23-bed
licensed psychiatric hospital.

Departmental responsibilities include direc-
tor of mental health services as well as gen-
eral medical administration associated with
the statewide supervision of physician, den-
tal, pharmacy, x-ray and laboratory services
at nine correctional facilities. Direct supervi-
sion is provided for 17 staff, as well as
direct/indirect supervision of physician staff
employed at nine facilities.

The DOC Medical Director makes clinical
contributions in inmate health care/pro-
grams and consults with medical staff at the
University of Iowa Health Center. This indi-
vidual is responsible for program develop-
ment and review, and makes
recommendations as well as consults with the
DOC Director and institution administrators.
The Medical Director participates in litigation
affecting the department.

Must be a Board-Certified psychiatrist of
physician with at least five years of medical
management experience in a correctional,
mental health, mental retardation or juvenile
correctional facility. Salary is negotiable
based on qualifications and experience and
includes a generous benefit package.

Submit resumes to W.L. Kautzky, Director,
Iowa Department of Corrections,
420 Keo Way, Des Moines, Iowa 50309 or
fax 515-281-7345.

Call 515-242-5703 for more information.
Resumes must be received by 6/30/2000.

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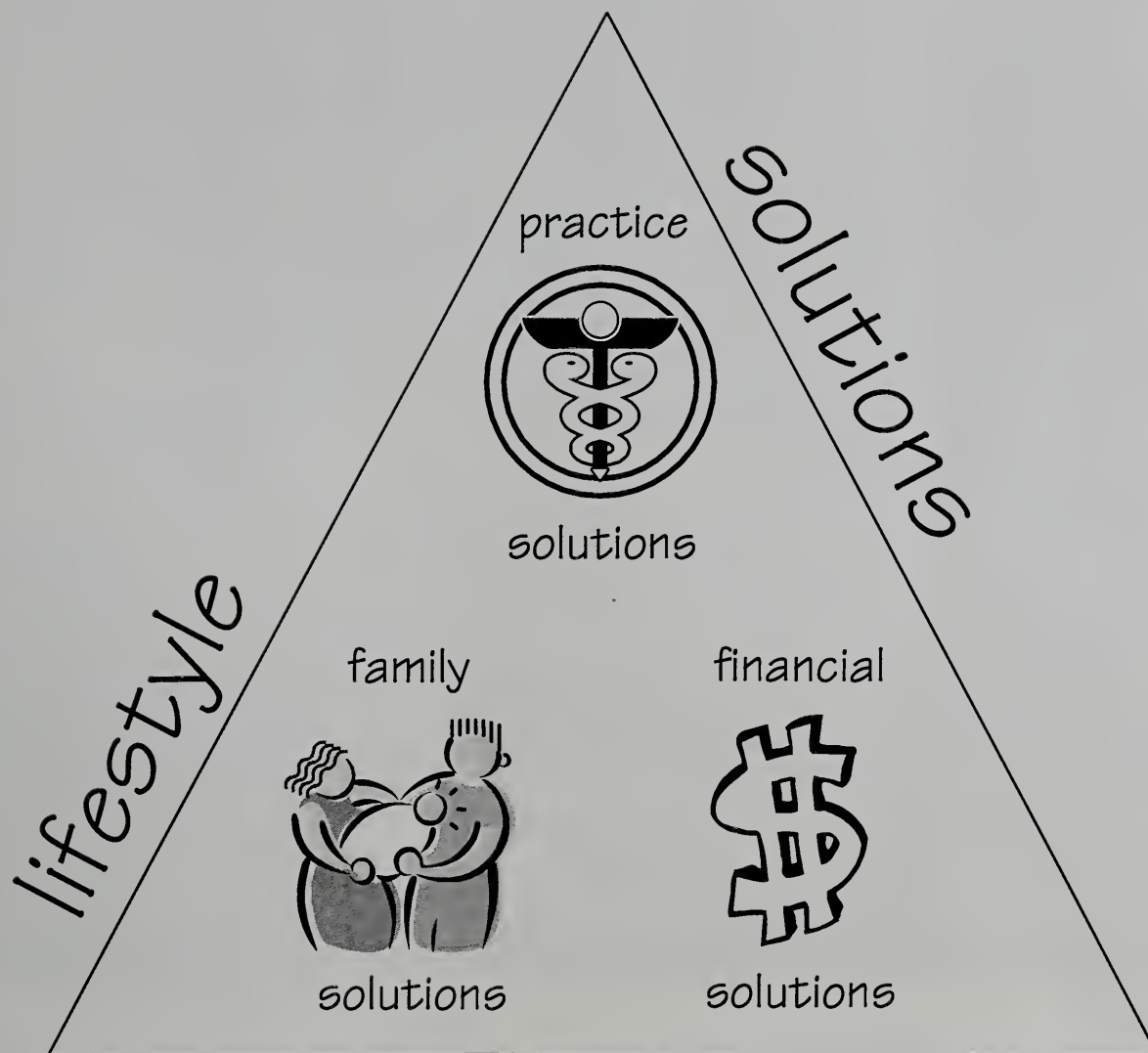
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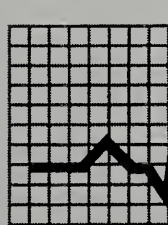
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Iowa Medicine

July/August 2000

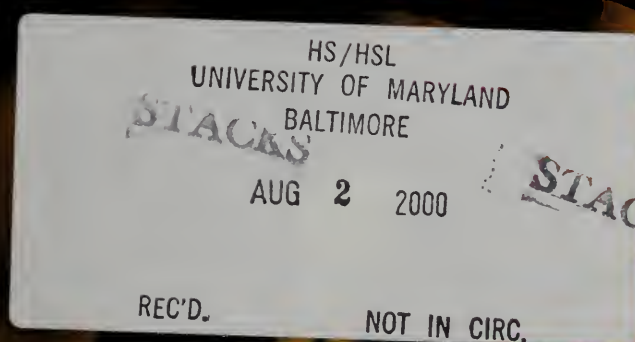
An Iowa Medical Society publication

1850-2000

50 Years

Medicine under a microscope

*Iowa physicians react to the IOM
report on medical errors — page 18*



How to talk to your legislators on scope of practice issues / page 8

AMA to Vilsack: please reconsider / page 11

IMS explores mediation resources and services / page 10

Internet directory — iowadocs.com — free to IMS members / page 16

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IowaMedicine

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A simple metaphor has a powerful message for physicians.

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10 legalities

Are you interested in alternative forms of dispute resolution? Please complete our survey on member needs!

11 ims advocate

In a June 2 letter to Governor Vilsack, AMA Executive Vice President E. Ratcliffe Anderson, MD, said assignment of benefits is "standard practice across the country."

16 med bytes

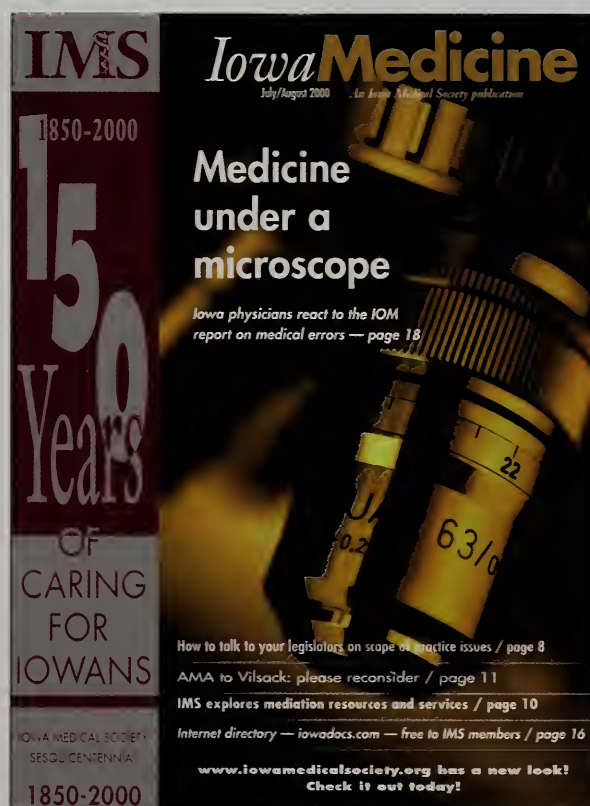
On August 1, IMS will launch iowadocs.com — a great opportunity for IMS members to promote their practices.

30 organ donation

Non-heart beating organ donation and transplantation dilemma.

34 new newsletter

UIHC releases new quarterly clinical newsletter — *Currents*.



This month's feature:

18 Iowa physicians react to the IOM report on medical errors.

REGULARS

- 13 your colleagues
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November 1, 2000

8 a.m. to 4 p.m.

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Iowa State University, Ames



Competent

Care

Across

Cultures

Kathleen McCullough Sanders from the Center for Cross Cultural Health in Minneapolis and a group of local experts present a program exploring the health needs of culturally diverse patients. As Iowa continues to become more diverse, meeting the needs of all cultures is vital.

The program is designed for physicians, physician assistants, advanced practice nurses, social workers, physical therapists, occupational therapists and other interested health care providers.

AMA category 1 continuing education credits are available for physicians, physician assistants and advanced practice nurses. CEU's are available for nurses and social workers. A certificate of attendance is available for all other healthcare professionals upon request.

To register or for more information, call the Mary Greeley Medical Center registration hotline at (515) 239-6864.

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A simple but **MEANINGFUL** metaphor



A bundle of sticks is hard to break, and so is a group of unified physicians.

by Sterling Laaveg, MD

We are now celebrating the Iowa Medical Society's Sesquicentennial year. At the 2000 IMS House of Delegates 150th meeting, a special appeal was made to bring the "Family of Medicine" together.

Many specialty societies came on Friday to hold scientific and/or business meetings. Some stayed for the weekend festivities. Their presence truly enhanced the weekend. The IMS received a great deal of positive feedback by those participating societies.

I remember a demonstration by my Boy Scout leader

when I was very young. Many of you have seen this done, but it speaks to why the coming together of the "Family of Medicine" is so important to our patient and physician advocacy.

My scout leader picked out the strongest, oldest member of our group and had him break a single stick easily. He then gave the scout 10 sticks, and the boy was unable to break the bundle.

It is a simple metaphor, but we need each of you and your specialty societies if we are to be powerful enough to change the legislative and regulatory processes of modern medicine.

It makes no difference whether you are a primary care physician or a specialty physician, you are very important to the IMS core purpose of assuring the highest quality of health care in Iowa through our role as physician and patient advocate.

Together we can be the powerful voice. Together we can make a difference. Please become or remain involved in the "Family of Medicine." We will ask you and all of our Iowa specialty societies to participate in the next IMS annual meeting.

If you or your society has an issue before the next IMS House of Delegates meeting, send it to the IMS Board of Directors for review or as a resolution. Our new bylaws allow the IMS Board to pass resolutions after a knowledge-based review between the House of Delegate meetings.

Please be there for our patients and your fellow physicians. We need your participation to become a physician "bundle of sticks."

It is a simple metaphor, but we need each of you and your specialty societies if we are to be powerful enough to change the legislative and regulatory processes of modern medicine.



Dr. Laaveg is an orthopaedic surgeon in Mason City and president of the Iowa Medical Society.



On Our Own Terms
Moyers on Dying

end-of-life care

IS there a *better way* TO DIE?

Isn't it time we talk about it?



September 10: Living With Dying
Focuses on people – patients and caregivers – who are searching for ways to recognize and talk about dying as more than a medical event. It is a part of life that each individual, in every American community, approaches with different attitudes, beliefs and wishes.

PHYSICIAN-FOCUSED PROGRAM
September 11: A Different Kind of Care — Examines the evolution of a new kind of care commonly referred to as “palliative care.” Leaders in this movement emphasize a full spectrum of pain management, symptom relief and support including physical, psychological and spiritual care.

September 12: A Death of One's Own — To many, dying well means having a measure of control over how we die. We fear dying in pain; we fear that too much will be done to keep us alive, or we fear that not enough will be done. This program looks at issues surrounding efforts to control how we die – including physician-assisted suicide – and the implications for family, institutions and communities.

September 13: A Time to Change
Follows crusading individuals who are working to change public policy to improve care of the dying. They are creating models for change that deal with issues including insurance coverage, medical training and support and relief for families who are shouldering the burden of caregiving when a loved one is dying.

Visit www.pbs.org/onourownterms
for more information.

Each year half the U.S. population is touched by the death of a close friend or relative.

A century of progress in medicine, nutrition, sanitation and technology has prolonged life dramatically. Along with this progress have come some unintended consequences. Today, dying takes longer, and for many that means living with pain.

ON OUR OWN TERMS:
Moyers on Dying, a four-part series documenting remarkable human stories of the dying as they struggle to live their final days and to share their deepest wisdom, will air September 10-13 from 8-9:30 p.m. each night on Iowa Public Television (IPTV).

People are looking for ways to make better care of the dying a routine part of

the American medical system. Part of the solution is to develop a new way of thinking about death – not as a failure of medicine – but as a natural part of life.

“You can’t control the inevitability of dying, but people are looking for the opportunity to have control over the difficult circumstances and complex choices at the end of life,” said Moyers. “Every family has different values, and they want those values to be respected and accommodated.”

The Iowa Medical Society has been involved with the Iowa Partnership for Quality Care in Dying with Dignity. **ON OUR OWN TERMS:**
Moyers on Dying is sponsored

by this group and IPTV.

Other IMS end-of-life care activities include


- The IMS Medical-Legal Committee will contribute uniform physician orders and other recommendations for the Partnership’s out of hospital DNR work group.

- IMS members are also contributing to work groups on pain as the fifth vital sign and community engagement.

- IMS members who received the AMA’s Education for Physicians on End-of-Life Care (EPEC) will contribute to local programs following the Moyers programs. For more information on EPEC, contact Norma Hirsch, MD, (515) 241-8128.

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SCOPE OF PRACTICE issues

Allied health professionals (AHPs) are an important part of the health care delivery system, but they are not physicians.

Iowa case law is clear that physicians are comprehensively trained health professionals who enjoy the legal ability to perform all medical practice acts. Professional standards and medical ethics assure that physicians provide competent, quality medical care.

AHPs, on the other hand, are limited by law in the scope of their practices. What they do intersects with medical practice, but they

cannot freely move into unauthorized areas of practice without a change in law.

IMS advocacy before the Iowa General Assembly often includes challenging scope of practice debates for a range of AHPs. The issue usually is framed by the request of an allied professional group for an expansion in their practice. Sometimes, the debate comes about when an AHP takes on new practice acts without legislative approval, claiming consistency with its existing practice law.

Legislators find scope of practice debates complex and frustrating. AHPs have single

issues and call out their troops in full force to lobby them. Lawmakers want to be responsive and will ask the parties to work out their differences — and often we do. When resolution is not reached, physicians then are seen by some as “protecting their turf.” Sometimes legislators believe that AHPs assure access to health services in otherwise underserved areas.

Physician input to lawmakers on scope of practice issues is critical. The IMS advocacy team is dedicated to representing physicians’ views, but lawmakers NEED to hear from the physicians in their districts. If they don’t hear from physicians, they assume the issue is not important to medicine.

What’s on the horizon for 2001? IMS expects non-nurse (lay) midwives to again ask for practice authority; nurse midwives to ask for a change in Medicaid rules to eliminate mandatory physician exams during pregnancy; physician assistants to ask for greater practice independence; and optometrists to ask for dispensing authority beyond topical agents.

Here are some dos and don’ts on how to talk to your legislators about scope of practice issues.

- Do focus first and foremost on coordinated, quality patient care managed by the physician.
- Don’t criticize or belittle the role of AHPs.
- Do tell how physicians and AHPs effectively work together.
- Do highlight the limited education, training and role of AHPs.
- Do help lawmakers to understand that technical skills in a limited area of practice do not transfer to comprehensive diagnostic and treatment situations.
- Don’t hesitate to give non-identifying care examples to highlight your points.
- Do answer all lawmakers’ questions fairly and forthrightly.

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WIN-WIN

Mediation of medical disputes

IMS members are interested in mediation services and resources.

by Jeanine Freeman, JD

The Iowa Medical Society conducted a survey to identify member needs. Mediation resources and services ranked high on the list.

Mediation and arbitration are two forms of alternative dispute resolution used to resolve a range of health care disputes. Physician contacts/agreements may require arbitration of disputes either as a necessary precursor to litigation or as the only avenue of resolution.

Litigation is time consuming, costly and public. It throws parties into opposite corners, and hostility and bitterness often remain.

Arbitration is similar to but less formal than litigation.

The parties present their case

to an arbitrator who renders a decision that is either binding or nonbinding; if nonbinding, the parties may reject the arbitrator's award but often use evidence from the arbitrator's record to then settle the case.

Mediation is voluntary and nonbinding. The process is informal, interactive and consensual. Mediation allows the parties to tell their stories but also requires them to identify the issues and goals of the mediation session.

The mediator plays a facilitative

role and is not a fact-finder or decision-maker — a key difference from litigation and arbitration. Successful mediation requires a shift in mindset from win-lose toward reaching a mutually acceptable result. Each party must be flexible, open to different options and willing to compromise.

IMS is exploring ways to effectively respond to our members interest in mediation services. Complete and fax us the following survey. Your input is important to us!



Jeanine Freeman is vice president of public policy and advocacy for the Iowa Medical Society. Information in this column is not intended to be legal advice. Call your attorney with specific concerns.

MEDIATION SERVICES — SURVEY

1. Would mediation services be a valuable IMS member service? ☐ Yes ☐ No
2. Mediation assistance would be helpful in the following areas (rank as many as you like in order of importance — 1 being most important):

<input type="checkbox"/> Medical staff disputes	<input type="checkbox"/> Medical practice/joint venture disputes
<input type="checkbox"/> Employment disputes	<input type="checkbox"/> Professional liability/malpractice disputes
<input type="checkbox"/> Patient disputes	<input type="checkbox"/> Disputes with regulatory/government agencies
<input type="checkbox"/> Vendor disputes	<input type="checkbox"/> Other (specify _____)
<input type="checkbox"/> Contract or payment disputes with third party payers/managed care companies	
3. I would like (rank as many as you like in order of importance — 1 being most important)

<input type="checkbox"/> A listing of available mediators and information about them
<input type="checkbox"/> Further information about mediation
<input type="checkbox"/> Conflict management/role playing sessions
<input type="checkbox"/> Other (specify _____)

Return to IMS, attention Jeanine Freeman, fax (515) 223-1401. Thank you!

Assignment of benefits is **'STANDARD'** practice'

On behalf of the American Medical Association (AMA), I communicate my disappointment over your veto of Iowa Senate File 2203. Passed by an overwhelming bipartisan majority of the Iowa House and Senate, the bill would have required insurers to honor a patient's decision to assign payment of insurance benefits to physicians who provide their care. The AMA believes the issues involved — and the insurance industry's disingenuous arguments — rise to the level of national concern.

To understand our concerns, it is necessary to recall the dynamic that led to the introduction of SF 2203. In 1998, Wellmark (primary opponent of this bill) introduced a "universal contract" for physicians that was obviously weighted in Wellmark's favor. Physicians had only 30 days to sign the contract, although Wellmark extended that time due to the response of physicians and hospitals.

Physicians could choose not to sign the contract and continue to see Wellmark patients as participating providers under stand-alone agreements, but Wellmark unilaterally amended those

agreements to implement a new RBRVS payment system that solidifies Wellmark's unique status as the lowest commercial payer for physician services in Iowa. Physicians finding both options unacceptable could elect to become non-participating providers, but there was a major hook: Wellmark subscriber agreements prohibit patients from assigning insurance benefits to a non-participating provider. Instead, the patient is paid directly, and the physician must collect from the patient.

We understand Wellmark representatives made no secret of the fact they anticipated this policy would pressure physicians into signing the universal contract or accepting unilateral payment terms in the stand-alone agreements — a typical health plan bullying tactic. Wellmark is the only health plan in Iowa that prohibits assignment of benefits.

Assignment of benefits is hardly a new practice for the insurance industry. Assignment of benefits is standard industry practice across the country and a practice insurers handle with systems already in place. To argue as

Wellmark did, that there are prohibitive cost increases involved, is misleading and typical of an industry that too often puts profits above patient care. Assignment of benefits does not increase insurance payments to physicians — it assures physicians receive payment due.

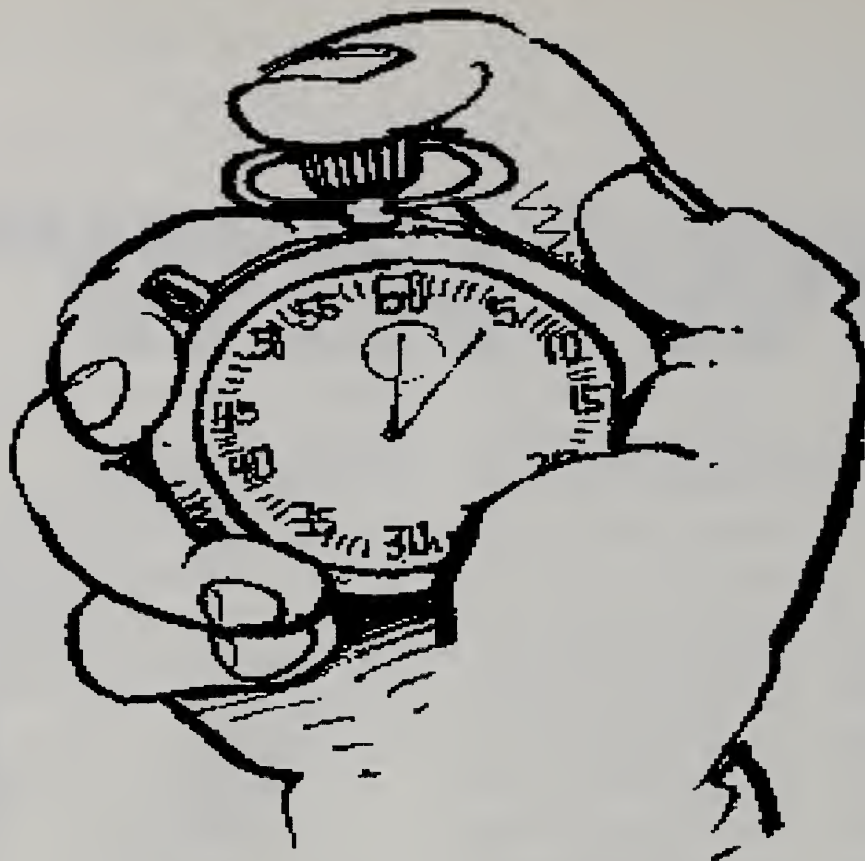
Wellmark's disingenuous "cost" argument also conveniently ignores the fact that prohibiting assignment of benefits adds to the already overwhelming administrative burden imposed upon physicians by managed care organizations and the insurance industry. Physicians must take further time and resources away from patient care to assure they receive compensation.

The AMA is committed to assuring balanced negotiations between insurers and physicians to protect the patient's ability to access health care services. SF 2203 was reasonable legislation that advanced this public policy position. Given the overwhelming support for the bill, I ask you to reconsider your position.

*E. Ratcliffe Anderson, Jr., MD
Executive Vice President, CEO
American Medical Association*



Governor Vilsack, given the overwhelming support for the bill [Senate File 2203], I ask you to reconsider your position.



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IOWA PHYSICIAN distinctions & AWARDS

ANDY MCGUIRE, MD, is the new vice president and medical director, utilization management for Wellmark.

MARY DAVIS, MD, is the new medical director, quality management for Wellmark.

MERCY MEDICAL CENTER – NORTH IOWA received a five-star report card from *Health-Grades.com*, Inc., reflecting the medical center's superior quality of care in coronary by-pass surgery, heart valve replacement and myocardial infarction (heart attack).

MARIANNE JACOBS, DO, has joined Mason City Clinic.

GARY JACOBS, DO, has joined Mercy Family Clinic – Northwood.

DON YOUNG, MD, was appointed to the National Mammography Quality Assurance Advisory Committee.

MICHAEL WELSH, MD, has been elected a member of the National Academy of Sciences.

CASS FRANKLIN, MD, and **ANDREW ISENBERG, MD,** completed the first kidney and pancreas transplant operation in central Iowa.

STEPHEN GLEASON, DO, was chosen by the White House to be part of a delegation representing the U.S. at the World Health Organization conference in Geneva, Switzerland.

JAMES BLESSMAN, MD, and **JAMES LOVELL, DO,** were featured in the *Des Moines Sunday Register* on March 19, 2000 for their devotion in serving as volunteers in Venezuela.

STEPHEN VANOURNY, MD, was presented the Excellence in Leadership award at the IH&HS Chairs Reception on April 18, 2000.

LEO MILLEMAN, MD, was inducted as a fellow with the American College of Physician Executives.

JULIANNE THOMAS, MD, is one of seven winners of this year's JC Penney Golden Rule award.

RICHARD NELSON, MD, has been promoted to the position of executive dean of the University of Iowa College of Medicine.

MARYGRACE ELSON, MD, will join the University of Iowa Family Care Center in North Liberty.

AARON HOLLEY, M4, received a \$2,500 stipend from the University of Iowa Cancer Center to study prostate cancer.

DECEASED MEMBERS

GEORGE AURAND, MD, 67, life, dermatology, Clinton, April, 2000

IMS welcomes NEW MEMBERS!

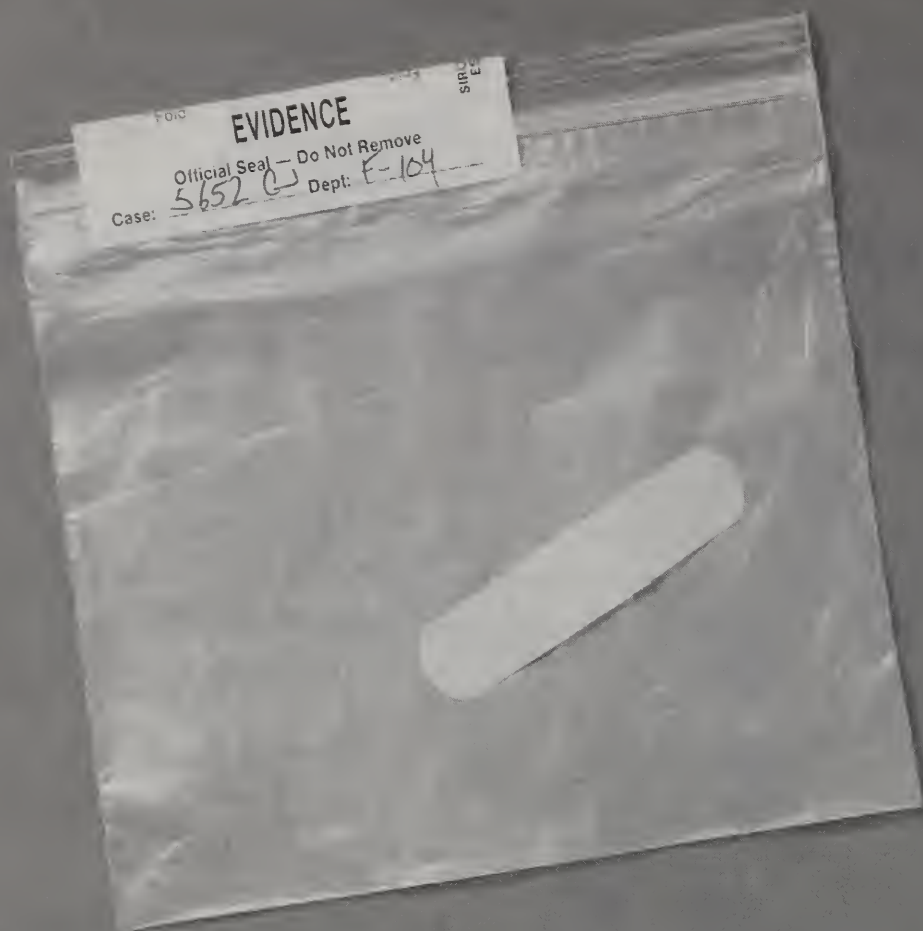
Members of the Iowa Medical Society join in welcoming the following new members into a progressive state medical association. The core purpose of the IMS is to assure the highest quality of health care in Iowa through our role as physician and patient advocate. Each new member is encouraged to join other IMS members at both local and state levels in achieving these goals.



Sanjoy Banerjee, MD, Cedar Falls
William D'Ambruoso, MD, Waterloo
Peter Hohnstein, MD, Waterloo
Tahseen Husain, MD, Waterloo

Mohammed Masri, MD, Waterloo
Michael Scott, MD, Dubuque
Alexander Spasic, MD, Oelwein
Darron Jones, MD, Mason City

Chester Dejong, MD, Rock Rapids
Bernadette Gyano, MD, Sac City
Zoltan Pek, MD, Sac City
Suhair Afana, MD, Sioux City



*e*xhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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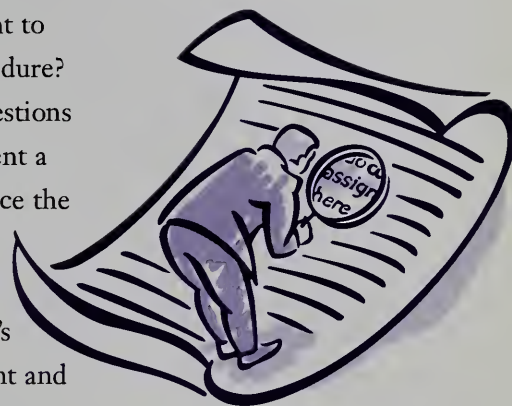
How does a physician with licensing problems or a history of sexual abuse problems end up practicing in your clinic? Or even someone posing as a physician? Too often it is due to inadequate credentialing.

What is a clinic's responsibility in checking provider references and verifying information? The provider's education, licensure, DEA status and certification must all be checked. At a minimum you must contact the medical/nursing school, state licensing board and specialty boards to verify the information. In addition, all personal and employment references should be contacted.

Should clinics grant privileges? There are no privileging requirements for free-standing clinics not seeking accreditation. But a practitioner's clinical competency needs to be considered and reviewed annually. To establish a credentialing policy, consider:

- ✓ Should providers be allowed to do whatever procedures they want in the clinic?
- ✓ What evidence should be required to ascertain competency to perform a procedure or treatment?
- ✓ What education, training and experience should be considered before allowing a provider to perform a new procedure?

- ✓ Who will decide if the provider is competent to perform a new procedure?
- Addressing these questions proactively could prevent a patient injury and reduce the clinic's liability risks. Credentialing is a necessary process in today's health care environment and essential to protecting your patients from any unreasonable risk of harm.



how we learn

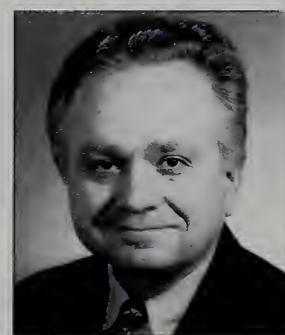
Teaching the SOCIAL contract

For generations physicians have made the commitment to provide medical care to all members of the community, regardless of ability to pay. This "contract" with society has become more complicated as the financing of health care, both public and private, evolves.

The business or economics of caring for people continues to force the making of choices. Physicians are reluctant to recommend treatments that will be at significant personal expense to patients. Patients themselves are increasingly sensi-

tive to the costs of care paid directly by them, especially as the price of procedures, medication and equipment has risen.

How does the new physician acquire an understanding of these issues? Certain facts can be taught during medical school and residency, but the most influence is generated by mentors. The attitudes and decisions of faculty, colleagues and specialty peers shape the perspective of the novice. Each of us possesses the opportunity to teach the meaning of the social contract.



This column is provided by Midwest Medical Insurance Company especially for Iowa physicians. For more information, call Lori Atkinson, MMIC risk management manager, at (800) 798-9870 or (515) 223-1482.

This column is written by Dr. Richard Nelson, executive dean, University of Iowa College of Medicine.

FREE Internet directory for IMS members

On August 1, the Iowa Medical Society will launch a new Internet directory. Patients will be able to search for IMS member physicians by name, city, specialty and/or county.

Beginning July 1, you will be able to view your directory page to verify information. You will also be able to add special features, such as practice philosophy, clinic hours,



areas of special interest and a photo.

Don't miss this chance to advertise your practice. In late June, verification letters were mailed to all Iowa physicians. Please take a moment to verify your information. This information will be used to update the

IMS Member Directory and iowadocs.com.

If you have any questions regarding iowadocs.com, please call Chris McMahon or Ed Whitver at the Iowa Medical Society (800) 747-3070 or (515) 223-1401.

Don't miss the new IMS web site
www.iowamedicalsociety.org
debuting July 10, 2000.

BIG CHANGES in the WORLD OF MEDICINE?



Big changes in the world of medicine are coming, and sooner than you think. By 2005, before you elect to let Dr. Slaughter perform your coronary bypass, you will be able to consult a national database that measures his performance against the performance of every other accredited thoracic surgeon in the country.

By 2007, your entire medical history, including the sequence of your genome, will be sorted on a data card in your wallet, or in a bracelet on your wrist or on a chip in your earlobe. This information will be "qualifiedly privileged." This means that your prospective spouse, employer, insurer, lender or business partner may have the qualified right to download and peruse some of this information before deciding to marry you, hire you, insure you or write you a 30-year mortgage loan.

Before 2010, telemedicine will be common. Doctors will diagnose disease, study scan images and perform surgical procedures via the Internet.

Is any of this really likely? The best response to these glimpses into the possible future of health care can be found in Eric Raymond's *The New Hacker's Dictionary*, now in its fourth edition and on the Net as Jargon File Resources www.tuxedo.org/~esr/jargon. — Excerpted from *Yahoo! Internet Life*, December 1999

AMA study finds physician Web use has doubled

The number of physicians using the Web has nearly doubled from 20 percent in 1997 to 37 percent in 1999, according to a study of physician usage prepared by the American Medical Association.

The AMA findings also showed that among physicians who use a computer but do not have access to the Web, 58 percent said they plan on acquiring access to the Web in the next six months.

In a similar study focusing on the habits of Iowa physicians, data showed that of the 91 percent of Iowa physicians who use a computer, 89 percent use e-mail and 91 percent use the Internet.

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The IOM report on medical errors . . .

Medicine **UNDER A MICROSCOPE**

Patients will be ill-served if naming, blaming and shaming are the result of the IOM report on medical errors.

by Chris McMahon



Chris McMahon is vice president of communications for the Iowa Medical Society.

Iowa physicians are poised to take action in the wake of the Institute of Medicine report on medical errors, and they are determined the action will be constructive.

According to the IOM report, released last November in a blitz of media attention, 44,000-98,000 inpatients die each year because of errors, with medication errors cited as the

leading culprit. In Washington, it became de rigueur to talk about medical errors; several congressmen introduced bills. Some of the proposals had troublesome implications because of their punitive nature.

"The public can easily understand the concept of harm and has a perception there are errors," says Ster-

ling Laaveg, MD, IMS president. "As a medical community, we can't ignore this issue. The public is looking to us to respond. However, the public will not be served if we fall into a trap of naming, blaming and shaming."

Dr. Laaveg, who has appointed an IMS task force to make recommendations on the issue of medical errors, was one of several Iowa physicians present for discussion of the IOM report at the June AMA Annual Meeting in Chicago.

A CAREFUL CHOICE

Dr. Lonnie Bristow, past president of the AMA, was on the committee that wrote the IOM report. He told the AMA House of Delegates the name of the report — "To

“ This report was not meant to attack anyone. It's the system of care we've been taught that is at fault. ”

Err is Human' — was chosen very carefully.

"The report was not meant to attack anyone," he explained. "It's not the doctors, it's not the nurses, it's the system of care we have been taught that's at fault."

The IOM report was discussed at length at a May meeting of the IMS Board of Directors. The discussion focused on system failures that lead to errors, and how physicians can help create a patient safety culture.

FOCUS ON THE SYSTEM

"I think physicians focus on their personal interactions with patients," commented Dennis Mallory, DO, a Toledo family physician and IMS Board member. "We tend not to focus on the system as much, especially if it seems to be working okay."

There was general agreement Iowa physicians are in an excellent position to begin an ongoing dialogue about patient safety.

"You fall into a routine in your own institution," commented Dr. Laaveg. "If other organizations are doing something innovative to address quality, you don't learn about it."

Charles Helms, MD of the University of Iowa Department of Internal Medicine, added, "Information about quality improvement initiatives shouldn't be treated as

proprietary and should be freely shared."

Tom Evans, MD, IMS Board member and medical director for Integra Health, said managing the potential for variability won't be easy.

As an example, he cited the medication errors which some are calling the 'low-hanging fruit' in the collective quest to reduce errors.

"There are 17 components in the process we follow to get the proper medication to a patient. An error can occur at any of those points," he explained. "If you eliminate variability at one of the

stages, you've solved only five to six percent of the potential problem."

Don Young, MD, University of Iowa radiologist and head of the IMS delegation to the AMA, said it is vital for Iowa physicians to "define our responsibilities." The Board and Executive Committee agreed and approved creation of the IMS Task Force on Patient Safety. The task force will study the IOM report and participate in discussions with representatives of other health care professions interested in quality. Members of the

“ Information about quality improvement initiatives shouldn't be treated as proprietary. ”

Recommendations in the IOM report "To Err is Human: Building a Safer Health System"

According to the Institute of Medicine report, our health care system lacks a systematic way to identify, analyze and correct unsafe practices. The report makes three recommendations:

Center for Patient Safety — The report recommends creation of a federal Center for Patient Safety within the Department of Health and Human Services. The agency would identify and analyze medical errors, develop tools and methods for educating consumers and issue an annual report.

Mandatory reporting — The report recommends establishment of a nationwide mandatory reporting system for serious preventable adverse events. (However, the exact nature of qualifying events is not discussed.) In testimony before Congress, then-AMA President Dr. Thomas Reardon expressed concern that mandatory reporting "could have unintended consequences and elicit less information than a well-designed voluntary program."

Voluntary reporting — The report recommends establishment of a nationwide voluntary reporting system to collect information on errors that cause minimal or no harm. It notes that voluntary reporting of less serious errors can identify patterns and systematic problems.

“
There is no such
thing as
mandatory
reporting. All
reporting
is voluntary.
”

newly formed IMS Health Care Executives Section will be asked for input. The task force will explore a fall conference in coordination with other interested entities.

Some of the same physicians on the IMS task force are also serving on the Iowa Department of Public Health Council of Scientific and Health Advisors, which has chosen the IOM report as one of its initiatives.

WHAT'S UP NATIONALLY?

Dr. Young is also a member of the AMA's Council on Scientific Affairs, which sponsored an education session on the IOM report held during the AMA Annual Meeting. Panelists included representatives of the avia-

tion and nuclear industries, which have both created successful non-punitive internal systems for reporting and correcting potential errors. Other speakers represented anesthesia, intensive care and cardiac surgery, specialties which experts believe have seen innovation in the area of patient safety.

There was plenty of talk about mandatory reporting systems and the risk of low compliance if the systems are punitive or lack peer review protections. Physicians at the AMA session also expressed concern over the effectiveness of mandatory reporting if information is discoverable by trial attorneys.

"The reality is, there is no such thing as mandatory reporting," commented AMA Trustee Donald Palmisano, MD. "All reporting is voluntary."

Twenty states have laws that mandate reporting of medical errors. However, definitions of what constitutes an error vary. (For example, blood loss during surgery which physicians said can be expected under certain circumstances is sometimes considered an error.) Experts also said states with mandatory reporting are each collecting different data and all lack sufficient resources to evaluate the data effectively.

Panelists agreed public accountability is "a huge

issue" and that there will be action by federal agencies. There could also be action by Congress, though observers believe this is unlikely in the near future.

"We will probably get a partially-funded federal mandate states will have to shore up," said Alan Nelson, MD, past AMA president and IOM member. "States will be charged with receiving reports, analyzing data and tracking reductions. No one knows who will fund this or what will be the role of accrediting and licensing organizations."

THE SCIENCE OF ERRORS

In the interim, panelists speculated, there will be voluntary efforts to address patient safety in institutions across the country. These will likely include relatively easy fixes such as renaming confusing drugs and marking surgical sites.

"We must apply the science of errors, as the airline industry has, as a way to educate and to improve patient safety," concluded Dr. Laaveg. "But, we must also find a way to let the public know that Iowa has very high quality medical care but that no system involving humans can be perfect."

IMS Task Force on Patient Safety

As of press time

- Charles Helms, MD (chair), Iowa City internist
- Dale Anderson, MD, Ames internal medicine
- Tom Evans, MD, Des Moines family physician
- Libby Lincoln, vice president of law and health policy, Midwest Medical Insurance Company
- James Merchant, MD, dean, University of Iowa School of Public Health
- Stephen Richards, DO, Algona family physician
- Staff support by Jeanine Freeman, IMS vice president of public policy and advocacy

Note: Drs. Richards, Helms and Evans are members of the Iowa Medical Society Board of Directors

How much **DO** you tip for ROOM SERVICE?

Many of us fear that we are either tipping too much or not enough.

by Jerry Foster

Summertime means travel time and family vacations — trips to the coast, the beach, Disneyland, Universal Studios, Epcot, the lake, the mountains, a resort, or Branson shows; golfing, boating, shopping, hotels, motels, dining or just hanging out.

If you partake in all or some of the above activities, you probably run into one of the major fears that plague Americans — tipping.

Do you ever wonder if you are tipping too much or too little? Most of us amateurs start to fidget, sweat and occasionally feel woozy when it comes time to tip.

We dread that snide under-the-breath remark from the

hotel bellhop. We wonder if the wait staff remembers that we left only 12 percent for dinner last month and spikes our food or drink with some alien substance.

Our nightmares consist of a monstrous baggage attendant, shaped like a professional wrestler, chasing us down after we slip them a folded up one dollar bill for loading three scale-breaking bags.

“Tipping brings out all sorts of insecurities, and often we are held hostage by this insecurity and tip more than the service warranted,” says Laura Daily in a recent article of Physicians Financial News. She gives us some great guidelines to ease our pain and anxiety.

- ✓ **Airport shuttle driver:** \$1 for a short hop, up to \$5 if he joyfully answers all your questions.
- ✓ **Bellhop/Airport baggage:** \$1-\$2 per bag.
- ✓ **Coat Check:** \$1 per coat.
- ✓ **Concierge:** Normal duties

should be tip free, but if he/she goes above and beyond, \$5-\$20 is appropriate.

- ✓ **Cruise ship personnel:** \$2.50-\$3 per person per day for your room steward and waiter, half that for your bus boy.
- ✓ **Doorman:** \$1 if he gets you a cab, especially on a rainy night.
- ✓ **Housekeeping:** \$1-\$2 per day per person. It's suggested that you tip daily in an envelope labeled housekeeping.
- ✓ **Maitre d':** If they squeeze you in because you are a loyal customer, \$5-\$20.
- ✓ **Room Service:** 15 percent of the bill, watch double counting.
- ✓ **Spa Personnel:** 20 percent of treatment.
- ✓ **Taxi driver:** 15-20 percent of fare, 50¢ minimum.
- ✓ **Valet:** \$1.
- ✓ **Waiter:** 15 percent for good service, 20-25 percent for exceptional service.
- ✓ **Buffets:** 10 percent.



Reed Rinderknecht, CFP, is director of client relations with Foster Capital Management. For a free initial consultation or more information about their Fee-Only services, please contact him at (800) 798-1012.



Jerry Foster is the CEO of Foster Capital Management, a fee-only financial planning and investment management company located at IMS headquarters, (800) 798-1012.

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We aren't afraid to stand up to big insurers

The assignment of benefits bill lets patients direct insurance payment to the physicians who provide the care. Wellmark pulled out all the stops but IMS and IHA sailed the bill through the Iowa Legislature with overwhelming bi-partisan support. The governor's veto does not mean IMS will go away quietly. We WILL be back.

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LOOK TO THE IOWA MEDICAL SOCIETY**

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Working for Iowa physicians and their patients

LET'S help the children

The recent deaths of two children in northwest Iowa make us well aware that child abuse continues to be an ongoing problem. Both of these children died at the hands of their parents or a parent's partner. Last year, 20,000 child abuse assessments were done by the Iowa Department of Human Services. Of those, only one third of the abuse cases were confirmed and 12 children lost their lives.



The death of a child due to physical violence is generally well publicized, but more than half of reported child abuse cases are due to denial of critical care.

Physical abuse accounts for less than 25 percent, while sexual abuse accounts for 10-15 percent. Of the 20,000 assessments made by DHS, the medical community reported only seven percent.

Efforts are being made by DHS to reestablish a pool of high-level experts consisting of physicians from around the state. Chuck Illg, DHS worker, and Steven Hayward, protective services specialist, said the DHS is able to call on physicians if sexual abuse is suspected, but they do not always have the luxury of vis-

iting with a physician for other types of child abuse.

The DHS's wish list includes a desire to have a couple physicians in each community to contact in all abuse cases. The DHS would also like to have physicians personally make the initial call to DHS in suspected abuse cases, which expedites the process. A third wish is that physicians remain understanding about the occasional need to get another opinion.

The system is not perfect, yet if the medical community and DHS continue to work together, the children of Iowa can be assured they are in the hands of

those who want to help them grow in a safe and healthy environment. As in any professional relationship, improved communication between physicians and the DHS can only help assure that the children involved in abuse cases benefit from the system.



This article was written by Ann Crouch, IMSA president.

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☐ Tuesday, October 17, West Des Moines – IMS Taylor Room
☐ Thursday, October 19, Cedar Falls – Holiday Inn University Plaza
☐ Tuesday, October 31, Cedar Rapids – Sheraton Four Points Hotel
☐ Wednesday, November 1, Davenport – Radisson Quad City Plaza
☐ Thursday, November 2, West Des Moines – IMS Taylor Room

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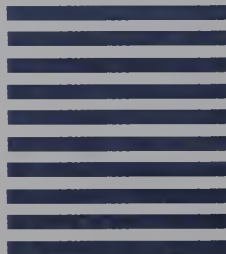
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The ROADMAP to significance

You must manage each area in your life with passion, balance and focus.

by Jerry Foster

In a previous article, I discussed some of the issues facing physicians today as they plan their futures.

One issue that continues to crop up is the underlying need most of us have to live a life of significance. We have spent our entire careers helping others, but eventually the quest for significance and fulfillment becomes larger in scope as we begin to ask ourselves about the legacy we will leave. The deeper question looms, "Who am I really affecting, and what will I be remembered for?"

This is the first part of a three-part series on the search for significance. This personal quest can only begin

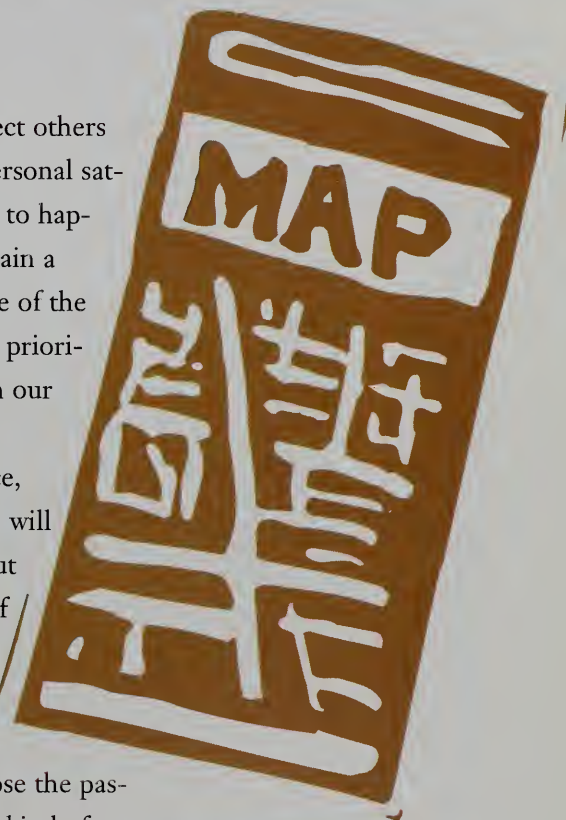
when we understand the importance of integrating and balancing our lives.

Many of us tend to compartmentalize our lives. It is as if we have a shelf called "life" with many different boxes on the shelf representing different priorities including faith, family, fun, fitness, friends, firm (career) and finances.

When dealing with any one of these areas, we tend to pull that box off the shelf and handle the realities of that particular issue. However, imbalance can result when

and positively affect others and experience personal satisfaction. For this to happen, we need to gain a proper perspective of the role each of these priorities should take in our lives.

Without balance, one of two results will emerge — burnout or complacency. If we burn out, we are of no use to anyone, let alone ourselves. If we lose the passion for life, what kind of



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MORE INFORMATION.**

we lose site of the rest of the shelf and spend an inappropriate amount of time in only one of the boxes.

If we are able to manage each of these areas with passion, balance and focus that we will be able to successfully

contribution are we making to the people we care about or the society we live in?

In part two of this series, I will focus on how to discover your life's passion and how to integrate it into all aspects of your life.



Jerry Foster is the CEO of Foster Capital Management, a fee-only financial planning and investment management company located at IMS headquarters, (800) 798-1012.

Non-heart beating ORGAN DONATION

These articles were contributed by Carol Scott-Conner, MD, head of the University of Iowa Department of Surgery.

Prior to 1968, all organ donations were non-heart beating organ donors. That year, Harvard Criteria for Brain Death Determination were developed and promulgated. By the late 1970s, the criteria had gained wide acceptance among the medical establishment and state lawmakers. Iowa's Brain Death Law dates back to 1978. Adoption of brain death laws meant that (at that

time) kidney donors did not have to be declared dead based on cardiac criteria before the organs could be removed. Organ donation could then occur while the patient was maintained on a ventilator with an intact heartbeat until just seconds before the organs were removed.

Today, non-heart beating organ donors are those patients who can not be declared brain dead. Typically, these patients have suffered severe brain injuries, yet they retain some brain stem activity. This activity is usually manifested by a weak respiratory drive. If the family wishes that this person be an organ donor, it may be possible. Determining factors include the strength of the patient's respiratory drive and cardiac rhythm. If it is likely the patient will experience a cardiac arrest within 60 minutes of withdrawal of ventilatory support, he/she may be a candidate for non-heart beating organ donation.

With the family's informed consent, the patient is taken to an operating room and prepped for abdominal surgery. With transplant sur-



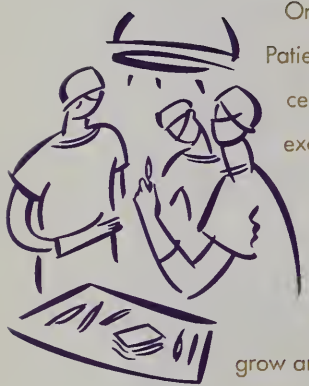
ORGAN DONOR SUITABILITY

The following conditions are NOT medical "rule-outs"

- ✓ Insulin dependent diabetes
- ✓ Hepatitis (A, B or C)
- ✓ Sepsis
- ✓ Advanced Age
- ✓ Smoking, alcohol consumption, tattoos and other life style choices

Currently, the only consistent medical rule-outs for organ donation are metastatic cancer and HIV.

The transplantation DILEMMA



Organ transplantation is no longer experimental. Patient and graft survival rates now exceed 80 percent for more transplantation procedures. Success exceeds 90 percent in both categories for kidney transplantation. The only constraint to greater success is a shortage of donated organs.

That is the irony of transplantation, the more people that are helped, the longer waiting lists grow and more people die while waiting. Not enough people say "yes" when approached at the time of a loved one's death. Often, it's because the donation was never discussed and the decision-maker does not know what the decedent wanted.

As a practicing physician, talk with your patients about donation or make a referral to Iowa Donor Network (IDN) when one of your patients is near death in an ICU. IDN has trained professionals on call 24 hours a day who can answer your questions about donor suitability and logistics. IDN staff will come to the hospital and sit down with the family to discuss donation options.

Today, because the need is so great, there are very few medical exclusions to donation. In Iowa, the liver of a brain-dead, 84-year-old has been successfully recovered and transplanted.

geons on "stand-by" in a nearby area, the patient is removed from the ventilator. Once cardiac arrest or a cardiac rhythm inadequate to sustain life is evident, the patient is declared "dead" by his/her attending physician. Once death is declared, the transplant team moves to the table and the organ recovery begins.

With swift surgical action and expert technique, it is possible to recover viable kidneys and livers for transplantation from these patients. For the family grieving the loss of a loved one, this form of organ donation can bring some comfort.

For more information, call the Iowa Donor Network at (800) 831-4131.

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TOP NEWS

AMA DISCUSSES death penalty

Some doctors sought a halt in executions as a medical issue

by Lindsey Tanner (AP)

The American Medical Association rejected a proposal Tuesday for a moratorium on executions, instead calling for "appropriate medical forensic techniques" to be used in capital cases.

Dr. Jonathan Weisbuch, author of the original resolution, had asked the AMA to recommend to the National Governors' Association that executions be halted until questions are answered regarding the availability of DNA evidence and the quality of legal representation for defendants facing the death penalty.

The AMA delegates voted in favor of an amended resolution to simply "support the availability and use of all

appropriate medical forensic techniques in the criminal justice system." Several physicians characterized the death penalty as a legal issue rather than a medical one.

The discussion comes in the midst of a national debate over the death penalty, heightened by Illinois Gov. George Ryan's moratorium earlier this year after medical evidence exonerated several death row inmates.

The original resolution, drafted by the American Association of Public Health Physicians, said "the possibility exists that in several states innocent individuals may be executed because medical technology will not be made available in time to prevent their death."

AMA Internet Health Road Show *Using the Internet for Better Health Care*

Thursday, October 12, 2000 • 8 a.m.-4:30 p.m.
Des Moines Marriott • 700 Grand Avenue • Des Moines, Iowa

This course, conducted by the American Medical Association and the Intel Corporation, is taught by industry leaders in medicine and technology. Through hands-on discovery sessions, participants will learn why patients access the Web, what tools are available to physicians and the latest Internet health care technology.

CME credit is available. For more information, visit www.ama-assn.org/about/roadshow/reg_info.htm, or call Tricia Murdoch at (909) 558-7252. The registration fee is \$95, which includes CME credit. The registration fee without CME credit will be \$70. Through a Midwest Medical Insurance Company educational grant, ALL physician attendees will receive a \$50 rebate upon completion of the program.

Attendance of 60 physicians is required, so be sure to bring your colleagues. Full refunds will be made if the event is cancelled. You will be notified of cancellation 15 days prior to program.

Co-sponsored by the Iowa Medical Society and the Midwest Medical Insurance Company

Mark your calendars, and watch your mail for more information!

AMA in cyberspace: Preparing physicians for the future

Whether teaching how to more easily surf the Web, helping put medical practices online or ensuring privacy and authentication on the Internet, the AMA is assisting physicians in their move to the electronic world.

Several important Internet-related activities took place at the AMA Annual Meeting:

INTEL HEALTH ROAD SHOW

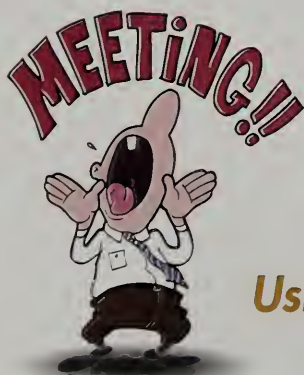
Physicians were offered a chance to explore where health care and technology currently intersect and what the future will bring.

INTEL DIGITAL CERTIFICATES

This innovative project is designed to preserve the confidentiality and integrity of electronically transmitted medical records and physician communications over the Internet.

MEDEM

Medem, with funding from the AMA and six other founding medical specialty societies, launched "Your Practice Online."





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2153 Westlawn
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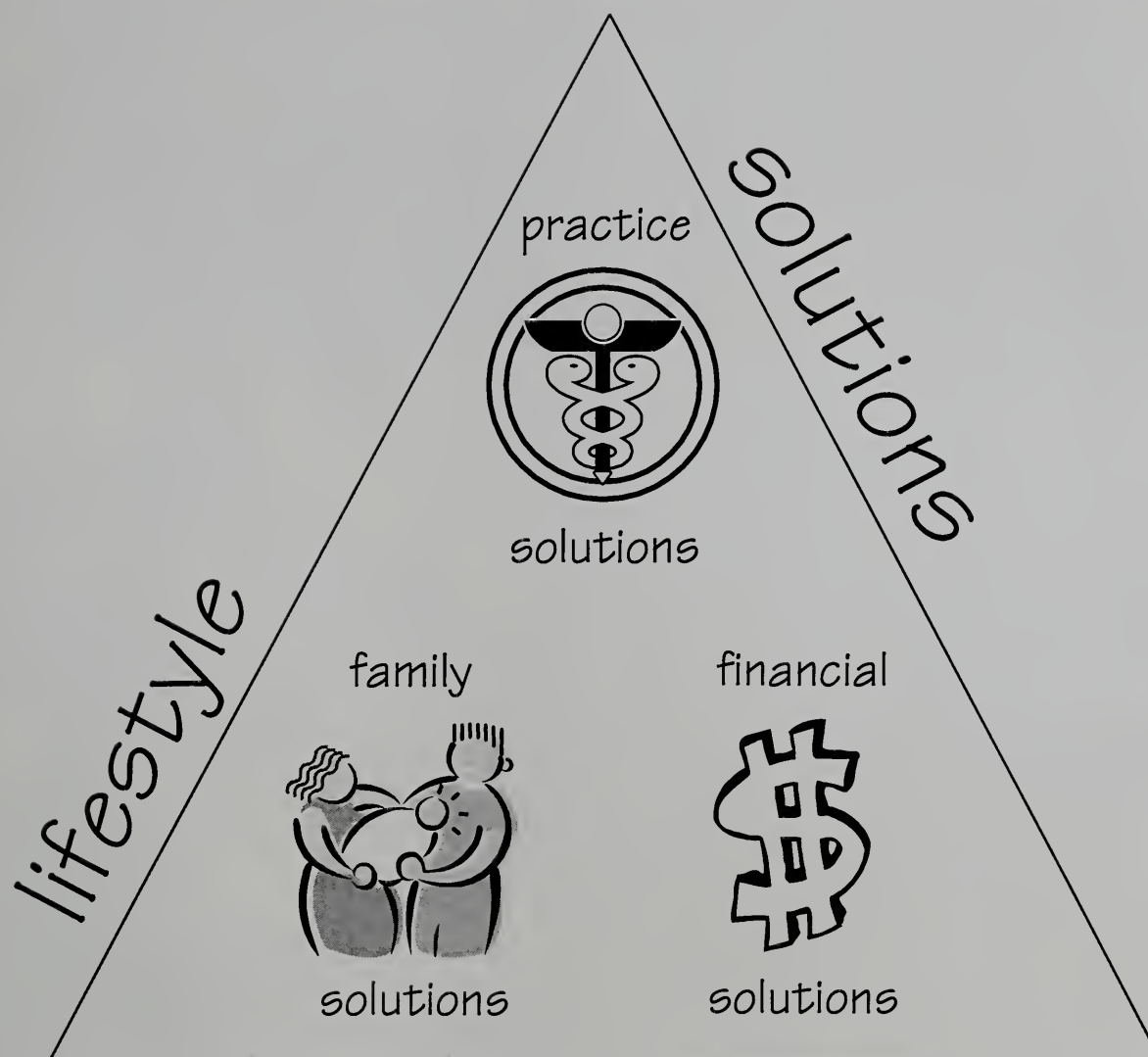
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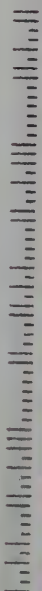
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Back to School

An IMS physician
earns her MBA— page 18

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Medicare lawsuit dismissal will be appealed / page 6

IMS will take assignment of benefits back to legislature / page 8

Antitrust laws — just who are they protecting? / page 9

HCFA's new audit instructions recognize undercoding / page 23

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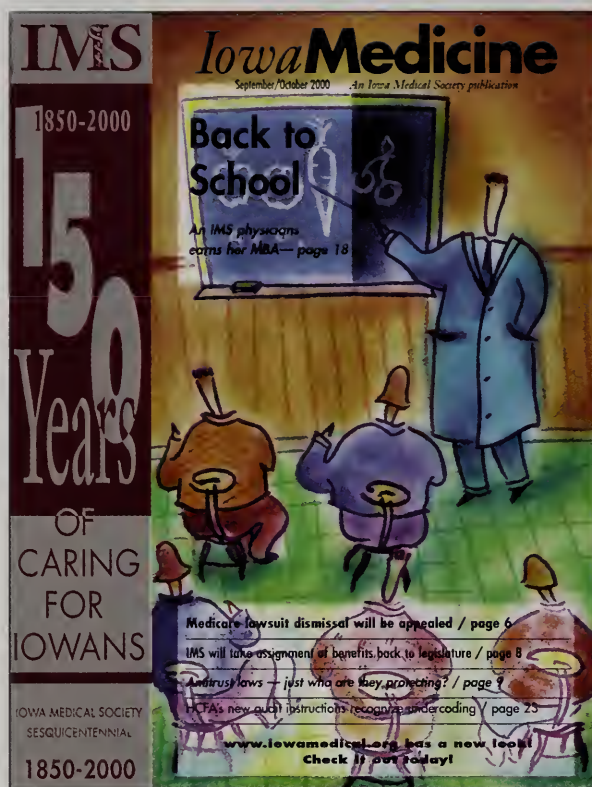
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COVER STORY

Back to school

Many doctors are seeking management degrees and business acumen to supplement their clinical experience.

Mary Hoppa, MD, a family physician from Davenport and IMS Board of Directors member, shares her MBA experience on page 18.

IMS CORE PURPOSE

To assure the highest quality health care in Iowa through our role as physician and patient advocate



Your colleagues have been busy! Check out what they've been up to, welcome new members and see what groups have 100% membership with IMS.

YOUR COLLEAGUES

PAGE 13

Are guidelines and pathways effective? There are a few issues you must consider when choosing your practice guidelines.

RISK MANAGEMENT

PAGE 15

In the past, female medical students were sometimes treated poorly by their male peers. However, there has been recent progress.

HOW WE LEARN

PAGE 15

In the past years, suicide and child killings have become more prevalent. Is there an explanation to these tragedies?

EDITORIAL

PAGE 21

CDC anticipates a shortage of influenza vaccine for 2000 and advises a delay in organized vaccination campaigns.

HEALTHY IOWANS

PAGE 24

The roadmap to significance continues with part two of this three part series: Discover your passion and open the door to significance.

SPECIAL SERIES

PAGE 29

IowaMedicine

Published by the Iowa Medical Society

September/October 2000

Vol. 90/5

6

ims advocate

Last month's feature focused on the Institute of Medicine report on medical errors. The Iowa Department of Public Health (IDPH) will receive funds to reduce medical errors in Iowa and, in a recent meeting with the IMS Board of Directors, IDPH Director Stephen Gleason, DO, said his efforts will focus on systems, not individuals.

7

president's comments

IMS President Sterling Laaveg, MD, wonders where patients figure in Wellmark's customer service equation. Is it good for Wellmark to marginalize the role of physicians and hospitals in patient care decisions?

9

legalities

As the Campbell antitrust relief bill struggles in Congress, physicians are mystified as to whom antitrust laws are supposed to protect. Read this incisive legal analysis for the answer.

23

your practice

HCFA has issued new instructions to carriers to ensure Medicare audits are fair and consistent. For the first time, carriers are instructed to take UNDERcoding into consideration.

30

IMS Retreat for Women Physicians

As the IMS gears up for its October 14 Retreat for Women Physicians, a new survey says women physicians are happy in their medical careers.

www.iowamedical.org
has a new look! Check
out what it has to offer
on pages 8a-8d!

the IowaMedicine team

IMS president

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Executive editor

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Managing editor

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Production coordinator

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IDPH director to **FOCUS** on systems, not individuals

Dr. Stephen Gleason, director of the Iowa Department of Public Health, told the IMS Board the IDPH will receive "substantial" federal funding to investigate medical errors. He made it clear his efforts to reduce errors will focus on systems, not individuals.

Dr. Gleason read the following statement to the Board: "I feel the IOM (Institute of Medicine) study on medical errors was shoddy, and the release was premature and for purposes unbecoming to the IOM.

"In addition, I believe most errors are system errors brought about by understaffing, the excessive burden of regulation and inadequate

financing of health services. Research I have conducted over the past several years will show that all the focus has been on reducing costs at the patient-provider interface with little attention on the 40 percent of every health care dollar spent on administration.

"With the help of the IMS

and other health professionals, I hope to follow the IOM's best (though the least prominent) recommendation focusing on systems, not individual practitioners. I will oppose the release of any information from the study such that it would make possible identification of the patient or practitioners."


Medicare lawsuit DISMISSAL will be **APPEALED**

The Minnesota Senior Federation (MSF) will appeal the recent U.S. District Court Decision to dismiss a lawsuit alleging discriminatory state-to-state Medicare reimbursement.

The IMS Executive Committee voted to financially support the lawsuit being brought against HCFA challenging the payment formula for the Medicare + Choice (Part C managed care) program. The suit was based on the case of a Florida woman who wished to move to Minnesota but was prevented from doing so because her Medicare benefits would be so much lower in Minnesota. The first hearing on the suit took place June 20 in federal

district court. The coalition which brought the suit argued HCFA's inconsistent treatment of Medicare beneficiaries violates their constitutional rights; government attorneys argued this is an issue for Congress, not the courts. The court agreed with the government, and on July 6 the suit was dismissed.

From the outset, legal analysts said lawsuits based on constitutional issues have a rough road to travel, but IMS leadership feels it is important to take a stand on the issue of inequitable Medicare reimbursement wherever possible. Iowa has one of the lowest per-beneficiary Medicare reimbursements in the country.



CONGRATULATIONS IMS MEMBERS!

The Iowa Medical Society has been selected by the Iowa Department of Public Health to receive a Governor's Volunteer Award for its outstanding contribution of volunteer service to the State of Iowa. Thanks to the IMS member physicians who have contributed extensive time and expertise to support the efforts of the Iowa Board of Health as well as local boards of health.

You are **NOT** a **WELLMARK CUSTOMER**

Wellmark Board members say no to voluntary implementation of assignment of benefits.

by Sterling Laaveg, MD

Wellmark says Iowa physicians and hospitals are not their customers. Perhaps we never were.

The Wellmark Board discussed a joint request from the IMS and the Iowa Hospital Association to voluntarily institute "assignment of benefits." Not surprisingly, the Wellmark Board voted against voluntary implementation. Wellmark Board members believe, by this action, they are serving their "customers" — the people who pay for their services. I take a longer view and wonder who will ultimately be served if Wellmark further alienates providers. More

importantly, I wonder where patients figure in Wellmark's customer service equation.

Remember the "assignment of benefits" legislation which passed the Iowa House and Senate last year by a large majority and was vetoed by Governor Vilsack at Wellmark's strong urging?

Remember the misleading, no-holds-barred campaign waged by Wellmark which called assignment of benefits "anti-consumer" and "a direct attempt to increase cash flow to providers?"

Remember the letter from the American Medical Association to Governor Vilsack telling him that assignment of benefits is "standard practice" across the country?

Remember Wellmark is the only Iowa health insurance company that does not voluntarily accept "assignment of benefits?"

John Forsyth has been told that his company's relationships with providers have never been worse. Wellmark

continues to enjoy not-for-profit status while at the same time marginalizing physicians and hospitals in critical decisions concerning patient care, patient benefits, reimbursement, payment method, strategic planning and insurance products, all supposedly on behalf of the people who pay for health care services. This seems at odds with the patient-advocacy message Wellmark markets for public consumption.

Modern marketers say everyone you deal with is your customer. Refusing to recognize this basic principle is arrogant and short-sighted. Who provides the services Wellmark's customers want to buy? The last time I checked, it was physicians.

Mr. Forsyth, you have a growing provider relations problem in Iowa. Physicians and hospitals are angry.

I think it would be good for patients if Wellmark counted physicians among its customers.



Dr. Laaveg is an orthopaedic surgeon in Mason City and president of the Iowa Medical Society.

Preparing for the 2001 General Assembly

Legislators addressing
the IMS Executive Committee
and Board of Directors

Senator Mary Kramer

Senator Mike Gronstal

Senator John Redwine

Senator Robert Dvorsky

Senator Johnnie Hammond

Representative Brent Seigrist

Representative Christopher

Rants

Representative David Schraeder

Representative Dave Heaton

Representative Brad Hansen

Representative Ro Foege

Steve Gleason, DO, director,

Iowa Department of Public

Health, also attended.

IMS HOSTS legislative and health policy leaders

Iowa legislative leadership and lawmakers attended meetings of the IMS Executive Committee and Board of Directors to address key health policy issues before the 2001 General Assembly. Discussion was open, frank and focused on what is the best policy for patient care.

MEDICAID

IMS and lawmakers agreed tobacco settlement dollars were fairly and wisely dedicated to health care and that Medicaid payment increases for physicians were overdue and deserved. Sterling Laaveg, MD, IMS president, said structured yearly Medicaid payment increases must be assured consistent with IMS statutory language tying Medicaid increases to Medicare; legislators noted the many and costly payment demands on the 2001 state health care budget.

ASSIGNMENT OF BENEFITS

IMS physician leadership emphasized the importance of patients' legal right to assign their health insurance benefits and reminded lawmakers Wellmark is the only marketplace insurer that

refuses to recognize it.

Laaveg informed lawmakers that despite significant negotiation efforts on the part of IMS, Wellmark has elected to stand its ground, thus posturing this issue for a return to the Iowa General Assembly. Lawmakers were generally sympathetic but noted that businesses and unions are concerned about the bottom line cost of health insurance.

HAWK-I

Laaveg reminded lawmakers of the longstanding IMS commitment to the Healthy and Well Kids of Iowa program, thanked lawmakers for voting to take the program to 200 percent of federal poverty and addressed IMS support of continuous eligibility for Medicaid children. Lawmakers conceptually support continuous eligibility but are concerned about its costs and whether other needs should have priority.

MENTAL HEALTH/ SUBSTANCE ABUSE PARITY

Laaveg noted the IMS position in support of parity and IMS support in 2000 of legislation that would have

taken steps toward full implementation of mental health parity. Lawmakers recognized the human and societal tragedies associated with mental illness and substance abuse and cost savings that could be realized through treatment and early intervention but noted the division among the parties on this issue. Concern on one side is with insurance mandates that lead to premium increases and drops in coverage and, on the other side, with a need to assure nothing less than full mental health/substance abuse parity.

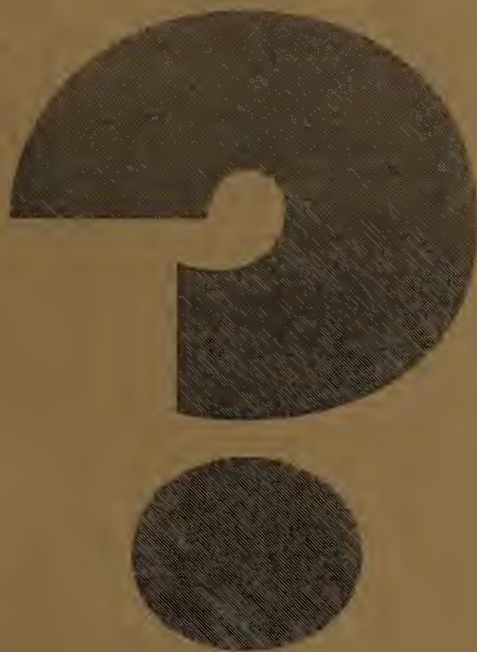
PUBLIC HEALTH PROTECTIONS

Laaveg highlighted IMS support for safety protections, particularly for children, including greater restrictions on smoking in public places, mandated personal flotation devices for children while boating and mandated bicycle helmets for children. Lawmakers split in their views, with some saying they cannot support legislation interfering with personal behaviors and choices.

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members only



Legislative updates, news from payers, public health issues, bill tracking chart

about IMS



IMS goals and governance structure, list of officers and staff, map to headquarters

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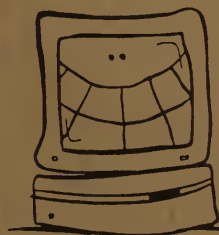
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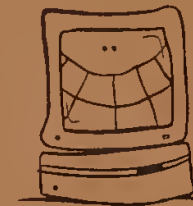
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A directory of IMS member physicians, complete with information for prospective patients

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ANTITRUST:

A nutshell analysis

Physicians are mystified as to whom antitrust laws are supposed to protect.

by Jeanine Freeman, JD

Antitrust laws appear counterintuitive in this day of mega mergers. Efforts to pass the Campbell physician antitrust relief bill only heighten confusion as to who antitrust laws are meant to protect.

Antitrust laws are regulatory mechanisms designed to assure a competitive marketplace, not to protect the competitor, however big, small, good or bad. Congress believes marketplace competition produces lower prices and better goods and services. The individual competitor must sink or swim in that competitive process.

Section 1 of the Sherman Act, prohibiting concerted action to restrain trade or commerce, is the best known

of antitrust laws. The Department of Justice (DOJ) is the enforcement agency. An agreement between distinct entities to restrain trade is key to a Sherman charge; the unilateral action of a single enterprise, such as an integrated medical group, to advance its interests in the marketplace is not covered. Evidence of concerted action need not be formal, such as a contract, but can be proven by words and actions. Concerted action can be between competitors (horizontal) or between non-competing marketplace players in a delivery line (vertical).

Courts interpret the Sherman Act as prohibiting concerted action to 'unreasonably' restrain trade and have developed two ways to test the reasonableness of the restraint. *Per se* violations are so pernicious and so unjustified as to be presumed as illegal even if done with consumer interests at heart. Most antitrust allegations, however, are measured by a

'rule of reason' analysis where the anticompetitive effects of an alleged restraint are balanced against its pro-competitive benefits.

Section 2 of the Sherman Act and section 7 of the Clayton Act prohibit monopolistic behaviors. The DOJ and the Federal Trade Commission (FTC) enjoy enforcement authority. Prohibited monopolistic actions require proof-of-market power; the relevant geographic and product markets must be defined, which is no easy task. Monopoly cases are difficult and expensive to prove and defend.

Government regulators have made it clear physician behaviors are subject to antitrust scrutiny. However, certain health care ventures structured consistent with 'safety zones' defined by the DOJ and the FTC can avoid further enforcement review. Physicians need not be bullied in fair and open negotiations by the antitrust laws. Caution is the key.

Fast facts on ANTITRUST

- Price fixing is *per se* illegal. It does not matter that the price agreed to by competitors is a minimum or maximum price. Uniform terms of sale and discount policies agreed to by competitors are forms of price fixing.

- Group boycotts, or joint 'refusals to deal,' are *per se* illegal. Boycotts among physician competitors usually take the form of a collective refusal to sign a contract or provide services unless or until a certain price is paid.

- Dividing the market among two or more competitors is *per se* illegal. Market allocation occurs where two physician groups agree each will provide only certain services or where physician competitors agree neither will participate in a plan/HMO in which the other participates.

- Certain behaviors, such as communications about prices or statements of solidarity in refusing to deal until certain conditions are met, raise antitrust red flags. Fact finding by a practice for legitimate business purposes can be conducted in ways that preclude unwarranted antitrust scrutiny.

- Physicians anticipating a venture that raises antitrust concerns should seek legal counsel. Physicians can lower legal costs by developing geographic and marketplace facts about the venture's likely impact on patient access to competitive services. Careful structuring can prevent antitrust violations.



Jeanine Freeman is vice president of public policy and advocacy for the Iowa Medical Society. Information in this column is not intended to be legal advice. Call your attorney with specific concerns.

MARK YOUR CALENDAR!



EXPLORING PARKINSON'S DISEASE: IMPACT, PREVALENCE AND TREATMENT

October 6, 2000
8 a.m.-3:30 p.m.

Mercy Education Center
5th & University • Des Moines, Iowa

*Sponsored by Mercy Medical Center –
Des Moines & Gerontology Society of Iowa*

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October 7, 2000
8 a.m.-4:30 p.m.

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*Sponsored by Mercy Medical Center –
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PURPOSE & OBJECTIVES: This educational conference explores one of the more baffling and complex neurological disorders: Parkinson's Disease. A growing number of older Iowans cope with this progressive neurodegenerative disorder each year. This conference will examine the likely causes of Parkinson's Disease, symptomology and diagnosis, as well as the various medical and surgical treatments and therapeutic interventions which are available. The most recent research findings and field applications within neurology and geriatrics will be detailed by the conference presenters. Health Care providers will be made aware of neurological assessments for Parkinson's Disease as well as the influences of medications, environmental toxins and genetic predisposition. New research findings will be presented on medications, therapy, surgical techniques and interventions (existing and experimental) for the treatment of Parkinson's Disease.

TARGETED AUDIENCE: Physicians, nurses, health care professionals

FACULTY: Dr. Randall Hamilton, Dr. Mary Louise Hlavin, Jim Andrikopolous, PhD and PT, OT, SLP panelist

REGISTRATION FEES

\$40 GSI members prior to 9/28/00 \$50 Non-GSI members
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Cost of the meal and breaks are included in the registration fee.

CONTACT: Aging Resources of Central IA (515) 255-1310

CME ACCREDITATION: This activity has been planned and implemented in accordance with The Essentials and Standards of Iowa Medical Society through joint sponsorship of Mercy Medical Center-Des Moines and Gerontology Society of Iowa. Mercy Medical Center-Des Moines is accredited by the Iowa Medical Society to provide continuing medical education for physicians.

CME DESIGNATION: Mercy Medical Center-Des Moines designates this educational activity for a maximum of 4.5 credit hours in Category 1 toward AMA Physicians Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the education activity.

NURSING: 0.5 CEU approved by Iowa Board of Nursing Provider #17

SOCIAL WORK: 5.0 approved. Mercy Medical Center-Des Moines is an Iowa Board of Social Work Examiners approved provider #61. This program is approved for 5.0 hours.

NEUROLOGY FOR PRIMARY CARE CONFERENCE

OVERVIEW: This CME activity is designed to interest and educate primary care practitioners and other healthcare professions. There have been many new and recent advances in the practical management of neurological disease. The latest techniques in diagnosis and treatment will be discussed.

PURPOSE & OBJECTIVES: All attendees should be able to discuss and apply the most recent advances in the diagnosis and management of:

- Dementia, including Alzheimer's disease
- Stroke, including prevention and acute therapy
- Seizures, including diagnosis and new medications and treatments
- Multiple Sclerosis, especially new treatments
- Movement Disorder, particularly Parkinson's Disease
- Neuropathy
- Headaches, particularly migraine

TARGETED AUDIENCE: Physicians, nurses, health care professionals

FACULTY: Michael R.K. Jacoby, MD, Medical Director; Bruce Hughes, MD; Randall Hamilton, MD; Paul Babikian, MD; Mark Puricelli, DO; Jim Andrikopolous, Ph.D

GUEST FACULTY: Lynne Geweke, MD, Director, Headache Clinic, Department of Neurology, University of Iowa Hospitals and Clinics, Iowa City, Iowa and Miroslav Backonja, MD, University of Wisconsin, Department of Neurology (unconfirmed)

REGISTRATION FEES: There will be no charge for this conference.

CONTACT: Jim Andrikopolous, PhD (515) 643-4500

CME ACCREDITATION: This activity has been planned and implemented in accordance with the Essentials and Standards of Iowa Medical Society through joint-sponsorship of Mercy Medical Center-Des Moines and Ruan Neurology and Clinical Research Center. Mercy Medical Center-Des Moines is accredited by the Iowa Medical Society to provide continuing medical education for physicians.

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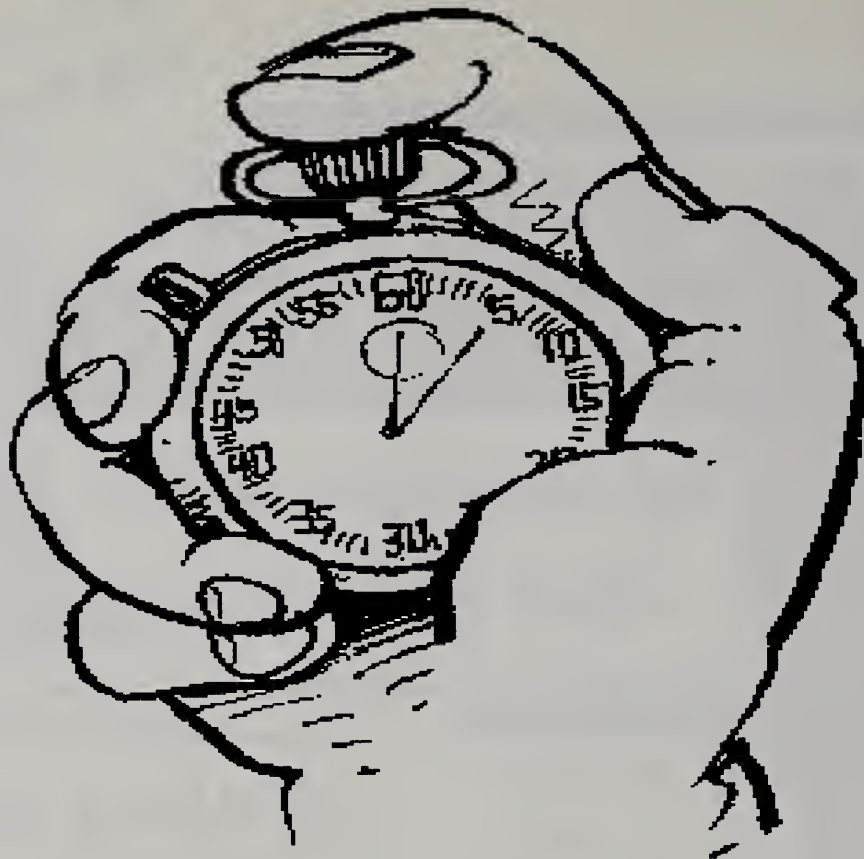
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IOWA PHYSICIAN distinctions & AWARDS

KURT ANDERSEN, MD; JOHN PATTON, MD; and JAMES PUTHAM, MD have joined Genesis Medical Center.

RON BERGMAN, DO, was featured in the *Business Record* for his renovated 19th Century mansion. It was called, "the most ornate physician's office around."

MARK THOMAN, MD, was named the new medical director at Broadlawns Medical Center.

UNIVERSITY OF IOWA HOSPITALS AND CLINICS ranks overall as one of "America's Best Hospitals" and 11 of the hospital's specialities rank among the nation's top 50 in the annual survey published by *US News and World Report*.

JOSE ANGEL, MD, represented IMS at an Iowa Department of Public Health press conference on selling prescription drugs on the Internet without a physician's exam.

STERLING LAAVEG, MD, participated in two radio interviews in Waterloo.

GREG HOVERSTEN, DO, is running for a House District 1 seat. Dr. Hoversten is a family and occupational medicine physician.

JOSEPH BUCKWALTER, MD, recently accepted an invitation to become a member of the prestigious Royal College of Surgeons of Edinburgh.

CONGRATULATIONS to the follow-

ing large physician groups for having 100 percent membership:

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Mercy Health Network-N. Iowa — Mason City
The Iowa Clinic — Des Moines
McFarland Clinic — Ames
The Iowa Heart Center — Des Moines
Radiology, PC — Des Moines
Radiology Consultants of Iowa — Cedar Rapids
Linn County Anesthesiologists — Cedar Rapids
Dubuque Internal Medicine — Dubuque
Medical Associates of Clinton — Clinton
Genesis Medical Group — Davenport
Physicians Clinic of Iowa — Cedar Rapids
Covenant Medical Clinic — Waterloo
Iowa Orthopaedic Center, PC — Des Moines

DECEASED MEMBERS

DONALD FABER, MD, 65, active, family practice, LeMars

WARNER PELZ, MD, 88, life, dermatology, Nashua, February 10, 2000

EDWARD FARRAGE, MD, 76, life, family practice, Council Bluffs, March 24, 2000

NOBLE IRVING, MD, 84, life, radiology, Des Moines, April 14, 2000

RAYMOND FRENCH, MD, 92, life, family practice, Newton, April 20, 2000

TOM THROCKMORTON, MD, 86, life, general surgery, Des Moines, June 21, 2000

BRUCE ANDERSEN, MD, 90, life, dermatology, Greene, July 1, 2000

IMS welcomes NEW MEMBERS!

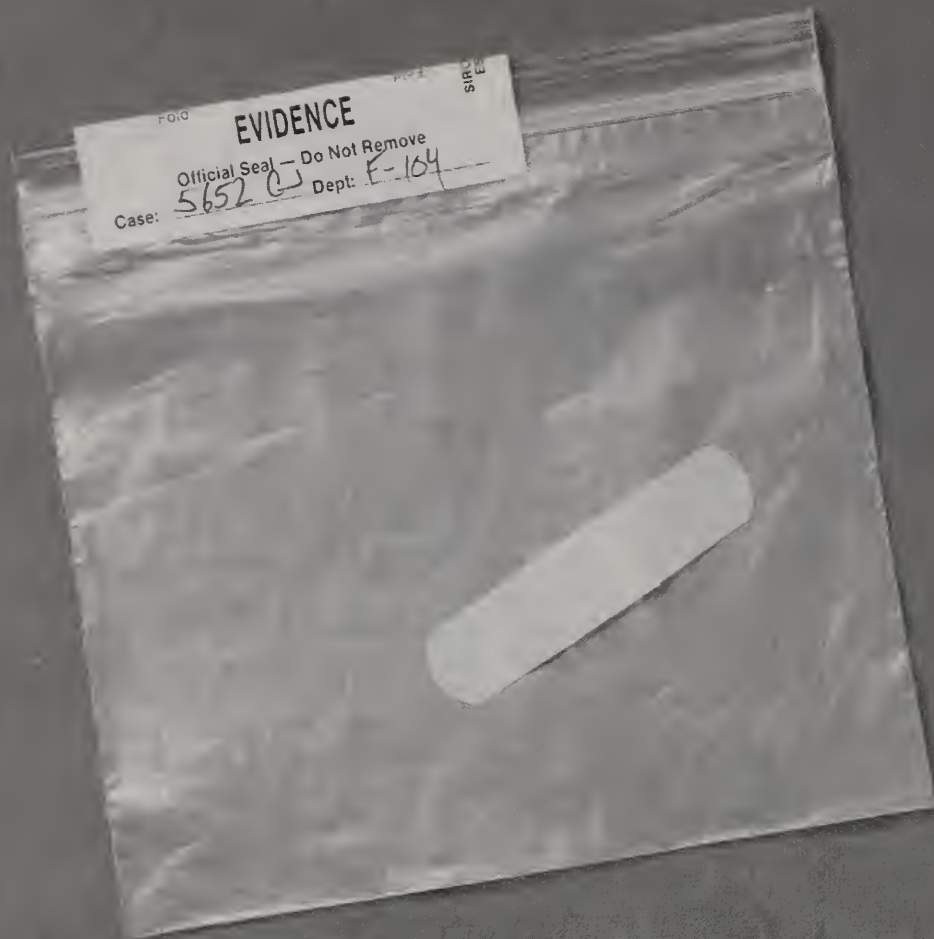
Stephen Frazier, MD, Waterloo
David Braun, MD, Cascade
Roger Shafer, MD, Dubuque
Ying Lu Nagoshi, MD, Cedar Rapids
Bradley Lister, MD, Marshalltown
Robert Young, II, MD, Marshalltown
James Meyer, DO, Fort Dodge
Eric Brandser, MD, Iowa City
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Shawn Simmons, MD, Iowa City

Douglas Cody, II, MD, Keokuk
Suresh Pothuru, MD, Centerville
Arun Chowla, MD, Bloomfield
Laurel Van Willigen, MD, Ottumwa
Jana Marjenhoff, DO, Corydon
Srinivasa Alla, MD, Des Moines
Atul Chawla, MD, Des Moines
Christopher Hauptert, MD, West Des Moines
Leslie Hillman, MD, Des Moines
Mary Louise Hlavin, MD, Des Moines



Anila Khan, DO, Des Moines
Harry Reed, DO, Des Moines
Donny Suh, MD, West Des Moines

Members of the Iowa Medical Society join in welcoming the following new members into a progressive state medical association. The core purpose of the IMS is to assure the highest quality health care in Iowa through our role as physician and patient advocate. Each new member is encouraged to join other IMS members at both local and state levels in achieving these goals.



*e*xhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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Guidelines and pathways: DO THEY HELP?

The use of guidelines and pathways has become more commonplace and more controversial over the past years. The recent reaction to the Institute of Medicine (IOM) study on medical errors suggests the use of guidelines could prevent many of the reported mistakes. How do you choose guidelines for your practice?

To address patient safety in your facility, first evaluate your current guidelines. Specialty societies have produced hundreds of guidelines on a wide variety of topics. Many hospitals and large clinics have implemented care guidelines for various specialties. MMIC recommends using guidelines published by, endorsed by, or adapted from your specialty society.

Use carefully-selected guidelines that will assist you most in your everyday practice. Whatever guidelines you choose to implement must be used consistently for

maximum effectiveness.

Before establishing a particular guideline as a standard within your facility, ensure that all practitioners are comfortable with its use.

Recognize that not every patient fits into a prepared guideline. This has been an area of controversy among practitioners. Some have expressed concern over being required to use guidelines when the patient's clinical

course does not

fit. From a risk management perspective, the important thing to remember is to document your reasons for departing from a guideline. A well-drafted guideline should explicitly allow for deviations based on an individual's condition.



how we learn

Our **WOMEN** doctors

The apocryphal stories of the treatment of female medical students by their male peers in the past now make us wince. How could men entering the healing profession of medicine be such louts?

In retrospect, many such men may have felt threatened by bright women aspiring to the same achievement. The standard reasons to explain male rejection of women in medicine, such as that the sensibilities of women were offended by many illnesses, are hardly credible.

There has been recent progress. Women are now about 42 percent of all entering medical students, but career expectations in some specialties and academic medicine still pose barriers to achievement for women. There can be no wavering in our commitment to equal opportunity for women in medicine. Our dedication to the fair and nondiscriminating treatment of all patients can only be achieved if we have a similar regard for **ALL** of our colleagues.



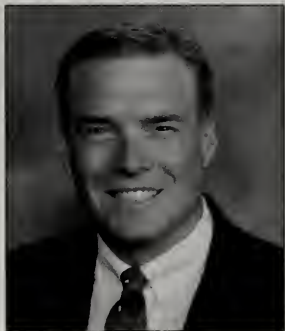
This column is provided by Midwest Medical Insurance Company especially for Iowa physicians. For more information, call Lori Atkinson, MMIC risk management manager, at (800) 798-9870 or (515) 223-1482.

This column is written by Dr. Richard Nelson, executive dean, University of Iowa College of Medicine.

COST of PROCRASTINATION



Ed Green is a senior financial analyst with Foster Capital Management, a fee-only financial planning and investment management firm located at IMS headquarters, (800)798-1012.



Reed Rinderknecht, CFP, is director of client relations with Foster Capital Management. For a free initial consultation or more information about their fee-only services, please contact him at (800) 798-1012.

Make planning for your future a priority, or you could lose out on potential free dollars.

by Ed Green

Most people spend more time planning for a vacation than they spend planning for their retirement. After all, there is plenty of time to plan. The “tyranny of the urgent” becomes the model for most people when allocating time to evaluate their financial condition and design a plan that will meet their objectives.

As the year unfolds, spring is busy and taxes are on the mind. “Let’s take care of this planning thing later.” As summer rolls around and schedules fill up, who wants to sit inside and organize and plan? “Let’s get the kids settled into school and then we

will be able to give this planning the attention it deserves.”

Of course, we all know what happens to our fall schedules and our priorities. “Let’s wait until the holidays are over and attack this after the first of the year.” The new year brings new resolutions and renewed purpose, but that long anticipated vacation south occupies our thoughts and we have to get a few things in order. “Then we’ll be ready.” But soon it is tax season and the cycle starts over.

The years roll by and the focus for that young couple

shifts from paying off the debt and getting settled to a strategy of accumulating “stuff” and making their mark in the world. Time gives way to thinking about college expenses and soon dissipates into a memory of what we could have accomplished if only there had been more time.

It boils down to making planning a priority. The cost of not doing this is significant! Don’t let the “tyranny of the urgent” rule the way you plan and how you position yourself to be financially independent.

INVESTMENT CHART

Starting Age	Value at 65 Investing Immediately	Value at 65 Starting 5 years later	Cost of 5-year delay
25	3,491,008	2,293,882	1,197,126
30	2,293,882	1,490,359	803,523
35	1,490,359	951,026	539,333
40	951,026	589,020	362,006
45	589,020	346,038	242,982
50	346,038	182,946	163,092
55	182,946	73,477	109,469
60	73,477	0	73,477

(Investing \$1000/month at 8% interest)

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The **CASE** for getting your MBA

Understanding the business of medicine is key to successful practices.

by Mary Hoppa, MD

Unfortunately, they do not teach business classes in medical school or residency. But guess what? If you don't understand the business of medicine, you won't be able to practice medicine (for very long). It's as plain and simple as that.

In the glory years of medicine (way before my time), doctors charged what they wanted and patients or insurers paid it. Doctors made a very good living without having to "run a mill" or having

the most efficiently run office. This was the era of "cost-plus pricing." This meant the doctor charged (and received) enough to pay his overhead and pay himself a reasonable wage above and beyond.

GLORY YEARS ARE GONE

We all know that we are no longer in the financial glory years of medicine. Third party payors with discounted fee for service, managed care contracts, capitation contracts and limited panels of providers have propelled us on the fast track into the business world. No longer can physicians sit by the wayside and guess what their costs are, or guess what they must be paid, or guess anything about the business

of medicine. There is little room for error in these guesses until it substantially hits the pocketbook of the physician.

Physicians are not the only ones affected by the change in payment mechanisms present today. Hospitals, ancillaries, durable medical goods, nursing homes and more are affected by the same financial issues as physicians. These areas have had one advantage — they have had financial systems in place with people to run them. These organizations have numerous individuals trained in financial analysis and management. Physicians complain that these organizations are run by "bean-counters" who leave the humanity out of the equation. Just as the business



Dr. Hoppa is a family physician from Davenport and the District 4 representative on the IMS Board of Directors.

world, in general, is trying to become more humane with a personal touch, maybe it's time for the physician world to become more business literate.

MISTRUST FOR BEAN COUNTERS

Doctors are data-driven. Yet, we mistrust much of the information hospitals or insurers give us. Maybe it's because we truly don't understand the information and how it was gathered, or like its implications. Maybe it's because we truly don't understand how to use the information to our own benefit. Maybe it's because we truly aren't interested in it.

Doctors like to excel. There is no reason the physician needs to be the financial dummy at a board meeting of any business whether it is the hospital, the office or the community church. The world of business is no different than the world of medicine; it has its own language and its own theory. Unless you can speak the language and know some of the theory, you will not be fully respected for your business opinion. Before I went to business school, I told people that I had attended the 'Seat of the Pants' business school — I had a lot of good ideas but they may not have been appreciated fully.

THE MBA EXPERIENCE

I just completed an Executive MBA program at the University of Wisconsin-

Madison. The two academic years spent with classes in Madison every other weekend was one of the best expe-

IS A MANAGEMENT DEGREE FOR YOU?

With the increasing demand of physician leaders, many doctors are seeking management degrees and business acumen to supplement their clinical experience.

Universities say physicians' interest in business degrees is skyrocketing, particularly for executive-type programs that let them continue working.

One sign of that interest is the burgeoning number of executive programs concentrating on health care. Of the 24 programs with health care focus, just eight are at least 10 years old.

For example, the University of Missouri has offered a master's of health administration since the 1960s but in an executive format only since 1991. "The executive mode is where the demand is," says Keith Boles, associate professor in the program.

"There's a lot of value in combining a clinical background with an understanding of managed care, negotiating and the business side," Boles says.

Executive programs require physicians to be on campus only at certain times during the year. Typically this might be every other weekend or for a handful of 10-day sessions throughout the course of the program. Another option for working physicians is evening classes.

For most physicians, the purpose of getting a management degree is to

advance their administrative careers, says Roger Schenke, American College of Physician Executives executive vice president. "In management, it matters what you have built, created or managed before," Schenke says. "What education does is help you build a track record."

At \$10,000 to \$54,000, degrees don't come cheap. Schenke suggests doctors take a few business courses or seminars first to make sure a degree is what they want.

Boles advises physicians to talk to graduates of a program they're considering and check out at least three before applying.

Generally, experts recommend physicians select programs with a health care focus if they plan to continue working in the field. Professors will use health care case studies to illustrate the concepts they teach.

Physicians also must decide whether to enroll in programs designed specifically for physicians or programs that draw from a variety of health care backgrounds. Advocates of the physician-only model say they can structure programs with physicians' needs in mind. Programs with the opposite philosophy say they provide a richer education because of the diversity of participants' backgrounds.

Reprinted from Modern Physician, December, 1999.

periences I've had. There is so much out there to be learned; information that can improve how we conduct not only the business of medicine but also our own personal business and how we interact with other medical-related businesses.

The post-WWII boom was a great time for the manufacturing businesses. As time went on and other competitors emerged (Japan, Europe), suddenly many manufactured goods became a commodity. Suddenly, manufacturers were told what people would pay for their goods and they needed to manufacture it at a lower price with room for an acceptable profit (price-based costing). This is exactly what has happened to the business of medicine. We have, in a way, become commoditized.

Just as doctors are data-driven, we also look to 'clinical' trials to give us an idea of how a treatment will work. We should consider the manufacturing industry as our 'clinical trial' and study what they have done and see what is applicable in the service industry of medicine. We shouldn't neglect the history of the manufacturing industry and repeat errors they have made in their quest for increased efficiency and decreased waste.

Just as manufacturing has

had to deal with being commoditized, they now look to 'value-added' activities that will allow them to receive revenue above and beyond commodity prices. We definitely pay more for a Lexus than we do a Ford; marketing further enhances the image of one product over another. In medicine, we need to market ourselves to insurers and patients for our 'value-added' activities beyond the routine medical experience.

MBA VS. MMM

There are two choices available for physicians who want advanced learning in the business area. The first is the traditional MBA (Masters in Business Administration); the second is a MMM (Masters in Medical Management).

MMMs are traditionally an off-site program with limited on site-time.

MBAs can be either fully on-site or off-site.

MBAs draw from a wide variety of industries whereas MMMs tend to draw from only medical-related industries.

I heartily recommend the MBA learning experience. An MBA program with on-campus classes leads to an educational environment in which you learn from your classmates (from all industries) as well as the faculty. The team

interactive experience is a highlight; it is a hands-on experience with team building, motivation, leadership and conflict resolution in a safe (school) environment.

WHERE DO WE GO FROM HERE

I have two favorite phrases: One is "Demand to Determine Your Own Destiny," the other is "Participate or Abdicate." I must be involved in the process where the future of my profession is determined. I must be knowledgeable in business to participate in the process. If I do not, I abdicate the right to determine my own destiny. Not every physician needs or wants to be a businessman. I would argue some physicians must.

Just as manufacturing businesses have tried to become more service oriented, service industries (medicine) have become more business-like. My hope is that medicine remains a fiscally sound industry; but we must never, ever forget our humanity and service orientation.

The **HORROR** of Suicide and child killing

Some situations are so tragic they seem to elude our attempts to explain them.

by David Drake, DO

As a child, I was fond of hamsters and sold them to my local pet shop. Early on, I learned if a mother hamster is disturbed by loud noises, she will kill her offspring.

Some human events are so tragic they seem to elude our attempts to explain them. Yet, other examples from nature may help us understand the imponderable suicides and child killings in Council Bluffs and earlier by Susan Smith in South Carolina.

Our closest genetic relative, the chimpanzee (with whom we share some 98 percent of our DNA) reflects our own species with wars, rape and infanticide as observed behaviors. Certainly

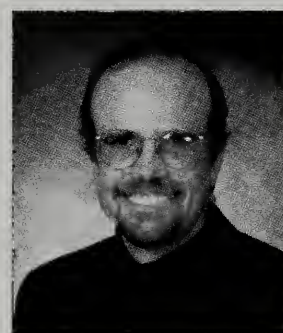
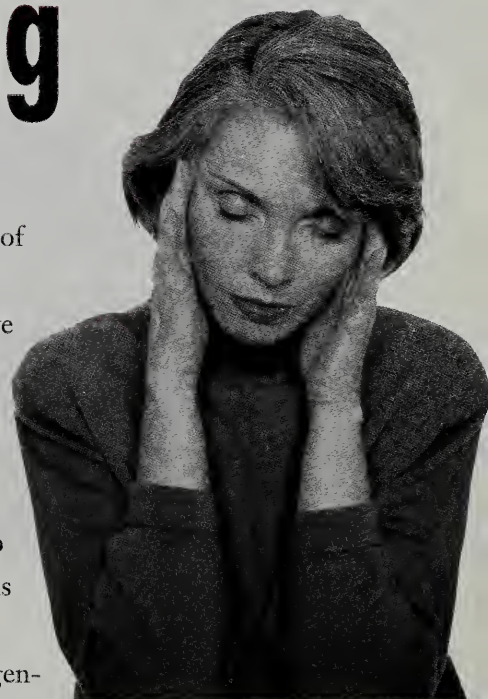
our social patterns are rooted in biology and have become part of human nature via natural selection. While it may seem a stretch to look at hamsters and chimpanzees for comparison, answers to recent tragic events may be found in a study of nature.

I don't know the Karen Duncan family. I am not suggesting anything about what should have been done in this tragic case. The easy answer is to blame managed care or the mental health system, or dismiss the problem as untreated depression. Of course, we need to look at the whole picture. Our families are not the same. Such behavior may not be predictable, except after the fact.

The problem goes beyond a 'chemical imbalance' or a diagnosis of depression. We need to see and work with the family while attempting to understand what the individual is reacting to. Too many persons in our mental health institutions become

calmer after several days of hospitalization — that is, until they once again have to interact with their families. Such disturbing behavior as suicide and murder of one's own children doesn't just crop up in one generation. It is tied, as we all are, to the functioning of previous generations and parental lines.

I don't know if Karen Duncan or Susan Smith had a psychiatric diagnosis. I do know and believe when the Iowa Legislature once again confronts the issue of mental health parity, any initiatives need to address coverage beyond the so-called 'brain disorders' of schizophrenia and bipolar disorder. Depression, severe anxiety and disorders of personality — the basic ability to get along in one's social setting — also deserve coverage. Without such coverage, people who suffer from these disorders have much less chance to improve their lives.



David Drake, DO, FAPA, clinical associate professor of psychiatry at Des Moines University – Osteopathic Medical Center and editor of the Iowa Psychiatrist, is in private practice in Des Moines. Send your comments to ddrakedo@uswest.net

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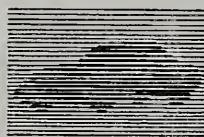
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HCFA issues **AUDIT** instructions

HCFE has issued new instructions to carriers revising the audit process to ensure the carrier's approach to medical review is fair and consistent. HCFA instructs carriers to factor in undercoding during an audit and to consider a physician's past history in determining a course of action. The following 10 points, effective October 1, provide carriers with the underlying principles of medical review.

The decision to conduct medical review should be data-driven. Data analysis may be undertaken as part of general surveillance or in response to complaints or other sources.

Validate potential problems by conducting "probe" reviews. Before using significant medical review resources, review a small "probe" sample to validate the hypothesis that claims are being billed in error.

Subject providers only to the amount of medical review necessary to address the nature and extent of the identified problem. Ensure that actions imposed upon providers for failure to meet Medicare rules are appropriate given the level of non-

compliance (e.g., a small level of non-compliance would not warrant 100% prepayment medical review).

When requesting additional documentation for medical review purposes, notify providers the documentation is to be submitted within 30 days. If the documentation needed to make a review determination is not received within 45 days, make a medical review determination based on the available documentation.

The provider error rate is an important consideration in deciding how to address the problem. Factors such as the total dollar value of the problem and past history of the provider should also be considered. When figuring provider error rate, subtract the dollar amount of charges underbilled.

Provider feedback and education is an essential part of solving problems. When a widespread problem is identified, ask medical and specialty societies to help educate. When a problem is limited to a small group, provide feedback on (1) the nature of the problems; (2) steps to be taken to address the problem; and (3) what steps you will

take to address the problem. Remove providers from medical review when they show compliance with Medicare billing requirements.

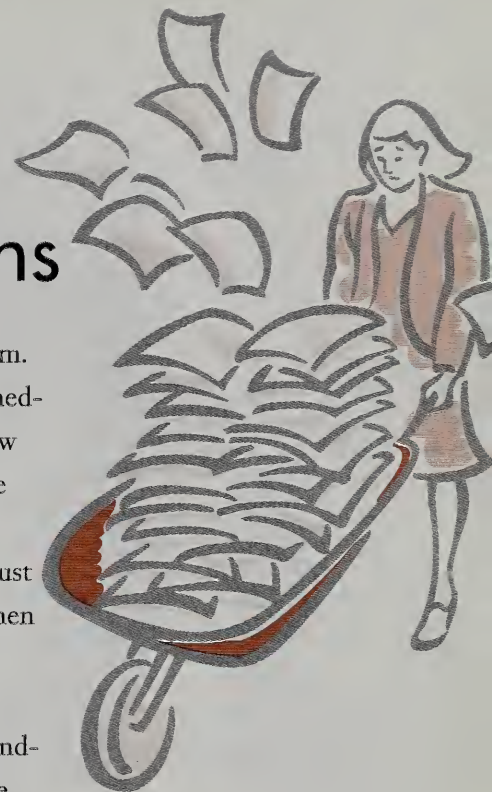
Written notification must be sent to all providers when they are placed on and removed from medical review. In the case of extended medical review, provide written notification at least every six months.

All overpayments identified must be collected or offset, as appropriate, as determined by HCFA directives and your overpayment collection procedures.

If the medical review detects possible fraud, refer the issue to the fraud unit.

Track interventions (reviews and education contacts) with individual providers through a provider tracking system (PTS).

Track and consider the results of appeals in your medical review activities. It is not an efficient use of medical review resources to deny claims that are routinely appealed and reversed. When such outcomes are identified, take steps to make appropriate changes in policy and procedure.



If you would like a copy of Medicare's Progressive Corrective Action flow chart, please contact Jennifer Lucas at the Iowa Medical Society.

If you would like to receive this and other billing/coding information directly and more quickly, email Jennifer Lucas at the Iowa Medical Society at jlucas@iowamedical.org and ask to join the IMS E/M list serve.

CDC and ACIP issue **ADJUNCT**

influenza vaccination **RECOMMENDATIONS**

For the 2000-01 influenza season, lower than anticipated production yields for the influenza vaccine component and other manufacturing problems are expected to delay distribution of the vaccine and possibly lead to fewer total doses. The CDC and Advisory Committee on Immunization Practices (ACIP) have the following recommendations.

Organized influenza vaccination campaigns should be delayed until November.

Influenza vaccination of persons at high risk for complications from influenza and their close contacts should proceed routinely during regular health care visits.

Purchasers should refrain from placing duplicate orders with multiple companies.

All influenza vaccine providers should develop a provider-specific contingency

plan to maximize vaccination of high-risk persons and health-care workers.

For additional information, watch the Centers for Disease Control Web site at www.cdc.gov.

IMS alliance

SHIGELLOSIS IN IOWA

Since January, cases of shigellosis in Iowa have increased a substantial 20-fold over levels reported at this same time last year. Such an increase is due to community-wide outbreaks in Clinton, Scott and Polk Counties, fueled largely by spread between young children in such places as daycare settings. Shigellosis is spread by person-to-person contact, not through contaminated foods (although foodhandlers can be a source of transmission). Transmission is facilitated by a low infectious dose. Treatment is generally supportive. Antibiotics can shorten the duration of illness and hasten elimination of the organism, but the growing problem of antibiotic resistance calls for their judicious use. To help control these outbreaks, it is important that persons with diarrhea be cultured. Those who test positive will be followed up by local health officials, who in turn can provide assistance in halting the spread of this outbreak. — Submitted by Cort Lohff, MD, MPH, assistant state epidemiologist, Iowa Department of Public Health

STOP America's Violence Everywhere



This article was written by Ann Crouch, IMSA president.

October 11 is Stop America's Violence Everywhere (SAVE) Day. Sponsored by the American Medical Association Alliance (AMAA), this day observes initiatives aimed at reducing violence.

Along with the Iowa Medical Society (IMS), the Iowa Medical Society Alliance (IMSA) is distributing Public

Service Announcements to television and radio stations across Iowa. The IMSA also printed 1,000 family violence posters to be distributed as well. The Iowa Department of Public Health is assisting the Alliance with distribution of these posters.

The AMAA also distributed a puzzle called Solve The Violence (aimed at 8 to

11-year-olds) to participating Iowa county Alliances free of charge.

Jane Lee, SAVE chair, is coordinating an effort to have IMSA brochures, "The Parent Antenna" and "Bullying," presented at a State Board of Education meeting with the hope that they will use these brochures in schools throughout Iowa.

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Professional listings give you the opportunity to acknowledge your staff and list your practice's name, address and phone and/or fax number. Each listing is placed under a heading that represents your specialty.

Professional listing rate is \$4 per line. *Iowa Medicine* is published six times a year.

If you are interested in placing a professional listing, please fax us your listing as you want it to read, a contact person, with contact fax and phone numbers. Upon receiving your information, we will return a proof copy/contract. Your signature will be used as a permission to print as seen on the contract. Contracts can be mailed to *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265 or faxed to (515) 223-8420.

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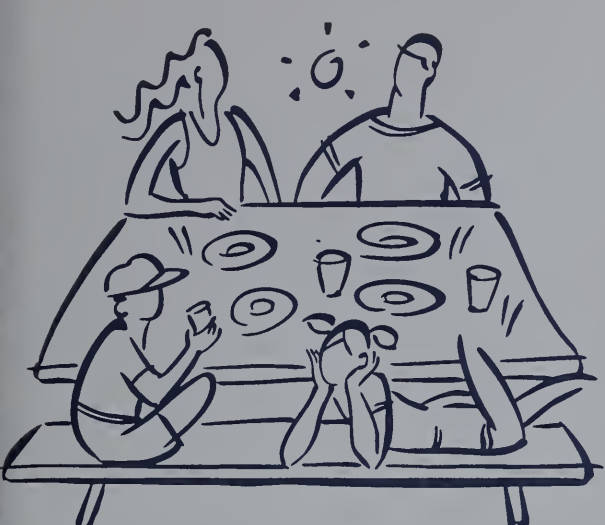
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How do I MANAGE confusion? When can I RETIRE?
How can I HANDLE retirement transition?
Will I be CONTENT? How do I find PEACE OF MIND?
Where do I START?

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I would like to attend the following Iowa Medical Society workshop (check one):

- ☐ Thursday, October 12, Sioux City – Hilton Sioux City
- ☐ Tuesday, October 17, West Des Moines – IMS Taylor Room
- ☐ Thursday, October 19, Cedar Falls – Holiday Inn University Plaza
- ☐ Tuesday, October 31, Cedar Rapids – Sheraton Four Points Hotel
- ☐ Wednesday, November 1, Davenport – Radisson Quad City Plaza
- ☐ Thursday, November 2, West Des Moines – IMS Taylor Room

Workshops will be from 4 – 8 p.m. with dinner included. Fee: \$75/individual; \$100/couple (please circle one) — Payable by check or credit card.

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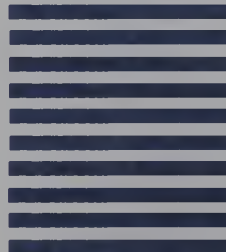
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The ROADMAP to **significance** (part 2)

Discover your passion
and open the door to
significance.

by Jerry Foster

In our last issue, I discussed the importance of creating balance in seven vital roles in our lives. If we are able to achieve that balance and develop proper focus, satisfaction and fulfillment will be the result and we will be well on the way to achieving significance. At the core of our pursuit of significance is an underlying "passion" that most of us never tap. Discover and understand that passion, and you will very likely find the key that will open the door of significance and impact.

In the movie *City Slickers*, Billy Crystal plays the part of a 40-year-old man in the midst of a mid-life crisis. In the midst of his struggle, he goes on a cattle drive and

meets a crusty old cowboy named Curly. In one scene, Billy asks Curly, "What is the meaning of life?" Curly looks at him and holds up his finger.

Billy asks him, "Your finger is the meaning of life?"

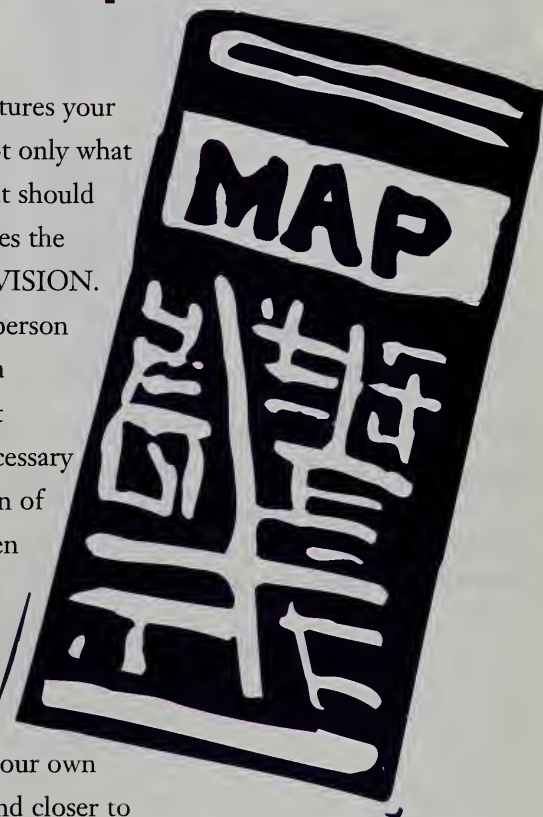
"No, it's that one thing," Curly replies.

"Well, what's that one thing?" Billy asks.

"That's for you to figure out," responds Curly.

What is that "one thing" for you? What's that issue that makes you pound the table with emotion or pace

vates you and captures your imagination of not only what could be, but what should be. This establishes the foundation for a VISION. Every successful person will tell you that a VISION for what "should be" is necessary for the completion of a great plan. When we begin to capture that passion, it adds a dimension of living that takes us past our own sphere of living and closer to achieving significance and



**DON'T MISS OUR
INTEGRATED LIFE
STRATEGY WORKSHOP.
SEE INSERT FOR
MORE INFORMATION.**

the floor when you talk about it? Without emotion in our lives, we face the risk of becoming complacent, self-centered and enveloped in mediocrity and routine.

Step back and take a good, hard look at what really moti-

experiencing a satisfying and fulfilling life.

In the next issue, I will discuss the importance of our legacy and what steps need to be taken to impact our families and future generations.



Jerry Foster is the CEO of Foster Capital Management, a fee-only financial planning and investment management company located at IMS headquarters, (800) 798-1012.



ON YOUR OWN TIME
Start the weekend off right! Make plans to meet other female physicians in Perry on Friday night. David's Milwaukee Diner, conveniently located in the Hotel Pattee, is busy on the weekends. Be sure to make your personal reservations EARLY!



THE PROGRAM

Saturday morning's session will begin with a leisurely breakfast. Arrive early and get caught up with your female colleagues.

Saralynn Mark, MD, senior medical advisor to the Office on Women's Health, Department of Health and Human Services and the National Aeronautics and Space Administration, will present

Technology transfer: From the birth of stars to breast health. Dr. Mark designed and completed one of the country's first Women's Health fellowship at the University of California, San Francisco. She has published and given lectures internationally on menopause, osteoporosis and other critical issues in women's health. She continues to teach medical students, residents and nurse practitioners.

Susan Johnson, MD, MS, professor of obstetrics and gynecology and associate dean for faculty affairs, University of Iowa College of Medicine, will enlighten you with **Alternatives to hormone replacement therapy.** Dr. Johnson directs the PMS Clinic at the University of Iowa Hospitals and Clinics' Women's Health Center and serves as medical director of the Family Planning Council of Iowa. She is truly **back-by-popular demand.**

Following the presentations, join your colleagues in a roundtable luncheon. Tables will be given a topic of discussion. Engage in roundtable discussions on key issues faced by women physicians. The meeting room has been reserved for an afternoon of open conversation.

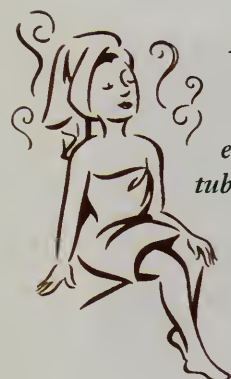
Sign of the TIMES

You asked for time to network... You asked for Dr. Susan Johnson...
You asked for a mix of business and pleasure...

The 2000 IMS Retreat for Women Physicians has it all!
Saturday, October, 14, 2000, Hotel Pattee, Perry, IA

It's time to take a few days off and relax in the luxurious Hotel Pattee with your female colleagues. This is a must-attend program for women physicians, residents and medical students coping with the demands of busy professional and personal lives.

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After a week of hard work, rejuvenate your body and soul in the Hotel Pattee's elegant spa. Soak in the spa tub. Purify in the steam room or dry sauna. Revel in a therapeutic massage. Release stress in the fitness

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IMS

Relaxation, networking and education brought to you by the Iowa Medical Society



Finish off your weekend enjoying Perry's Calico Shops and Thymes Remembered Tea Room, numerous antique shops, parks and museums.

Women physicians are **sold** on medicine

Women physicians are a robust, healthy group that's sold on medicine, according to Atlanta preventive medicine specialist Erica Frank, who surveyed 4,500 women about their well-being. In a study published in the *Archives of Internal Medicine* last year, she reported that 84 percent were generally satisfied with their careers.

In the space of 30 years, the percentage of physicians who are women has grown from a tokenish 8 percent to 23 percent. Almost half of first-year medical school students in 1999 were women.

However, women physicians are catching up. In 1991, they earned on average 65 percent of what male physicians earned, according to a *Medical Economics'* Continuing Survey. By 1998, they were up to the 72 percent mark.

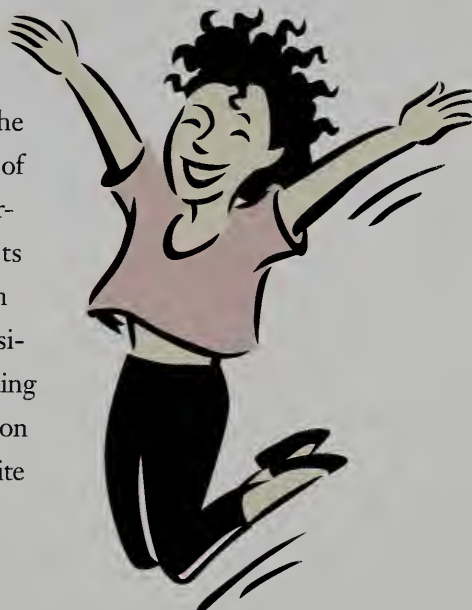
Women are particularly vulnerable to low-ball salaries because 56 percent of them are employees, as opposed to practice partners or shareholders. In contrast, only 35 percent of male doctors are employees.

The persistence of harass-

ment is a strong predictor of career dissatisfaction. In Frank's Women Physicians' Health Study, 48 percent of those surveyed reported being hassled in a nonsexual manner simply because they were women, however it was more likely to have happened in medical school and residency than in private practice.

Thirty-seven percent of those surveyed reported hav-

ing been sexually harassed. The Association of Women Surgeons' posts articles from female physicians regarding harassment on their Web site (womensurgeons.org).



Women MDs **CONTINUE** to earn **LESS** than men

Although women make up an increasing proportion of America's doctors, they continue to earn less than their male colleagues, according to a new survey conducted by the University of Pittsburgh.

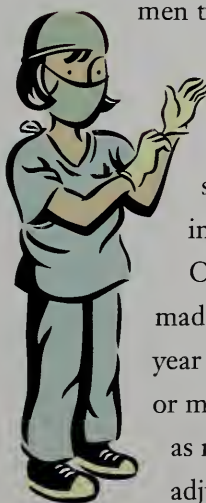
The researchers surveyed 232 male and 213 female internists currently practicing in Pennsylvania, all of whom had been out of medical school for 10 to 30 years. Eight-five percent were in their 40s or 50s.

"Women were more likely

to be salaried employees and less likely to be partners.

Women were half as likely as men to be in high-earning specialties and twice as likely to be in low-earning specialties," according to the report.

On average, men made almost \$63,000 a year more than women, or more than half again as much. Even after adjusting income for age, training and practice characteristics, the researchers report that men still made 14 percent more than women.



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MEDICINE
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During Women In Medicine Month, we gratefully acknowledge the participation and support of our female members. Women represent the fastest growing membership segment in the AMA. With this increased voice we can make a difference. I encourage all female physicians and medical students to become members. Your patients and your profession depend on your commitment.

Together, we can achieve real and lasting changes on behalf of our patients. Please support the AMA as well as your state and local medical associations. Join today.



"For me, being a physician is a calling. I have to try to make it a better world because I've been given so much."

Nancy H. Nielsen
2001 Vice Speaker,
AMA House of Delegates

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Join the AMA and your state and county medical associations. For information about free membership in the AMA Women Physicians Congress, call 800 AMA-3211, ext. 4392

Geriatric Grand Rounds

presented by the
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This continuing education activity is of particular value and importance to physicians who work with the geriatric patient. All health practitioners are invited.

Broadcast over digital communication networks that are accessible in many hospitals in Iowa, Grand Rounds will be delivered from Noon-1 p.m.

2000 Schedule

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For more information, call
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Des Moines, Iowa—Primary Healthcare, Inc., a partner of Broadlawns Medical Center, currently has an opening for a full-time BC/BE Family Practice Physician. This position will be located on the Broadlawns campus and will involve outpatient clinic responsibilities. Broadlawns is a public hospital and serves the diverse population of Polk County. Candidates bilingual in Spanish and English strongly urged to apply. Visit our Web site www.broadlawns.org or send CV and introductory letter to Medical Staff Services Office, Darlene O'Brien, Director, Broadlawns Medical Center, 1801 Hickman Road, Des Moines, Iowa 50314-1597, Phone (515) 282-2319, Fax (515) 362-4034, E-mail dobrien@broadlawns.org.

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BRACHIAL PLEXUS INJURIES

The Iowa Department of Public Health reports approximately 46 children per year are diagnosed with obstetrical brachial plexus palsy. Dr. John Laurent, chief of neurosurgery, Texas Children's Hospital, will be presenting academic lectures to physicians, residents and other medical professionals at medical institutions in Iowa, on brachial plexus injuries from October 9-13.

Tentative itinerary:

Monday, October 9

Finley Hospital
Dubuque, 11 a.m.-1 p.m.

Physiotherapy Associates
Cedar Rapids, 5-6 p.m.

Tuesday, October 10

St. Luke's Hospital
Cedar Rapids, 7:30-8:30 a.m.

St. Luke's Children's Therapy Group, 8:30-9:30 a.m.

Uni. of Iowa Family Practice
Iowa City, 12:15-1:15 p.m.

Wednesday, October 11

North Iowa Mercy
Mason City Telemedicine Conf.
Noon-1 p.m.

Covenant Hospital
Waterloo, 4-5 p.m.

Thursday, October 12

Broadlawn's Medical Center
Noon-1 p.m.

Friday, October 13

Council Bluffs/UNMC

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Interstate Postgraduate Medical Association of North America

Primary Care Update

October 23-26, 2000

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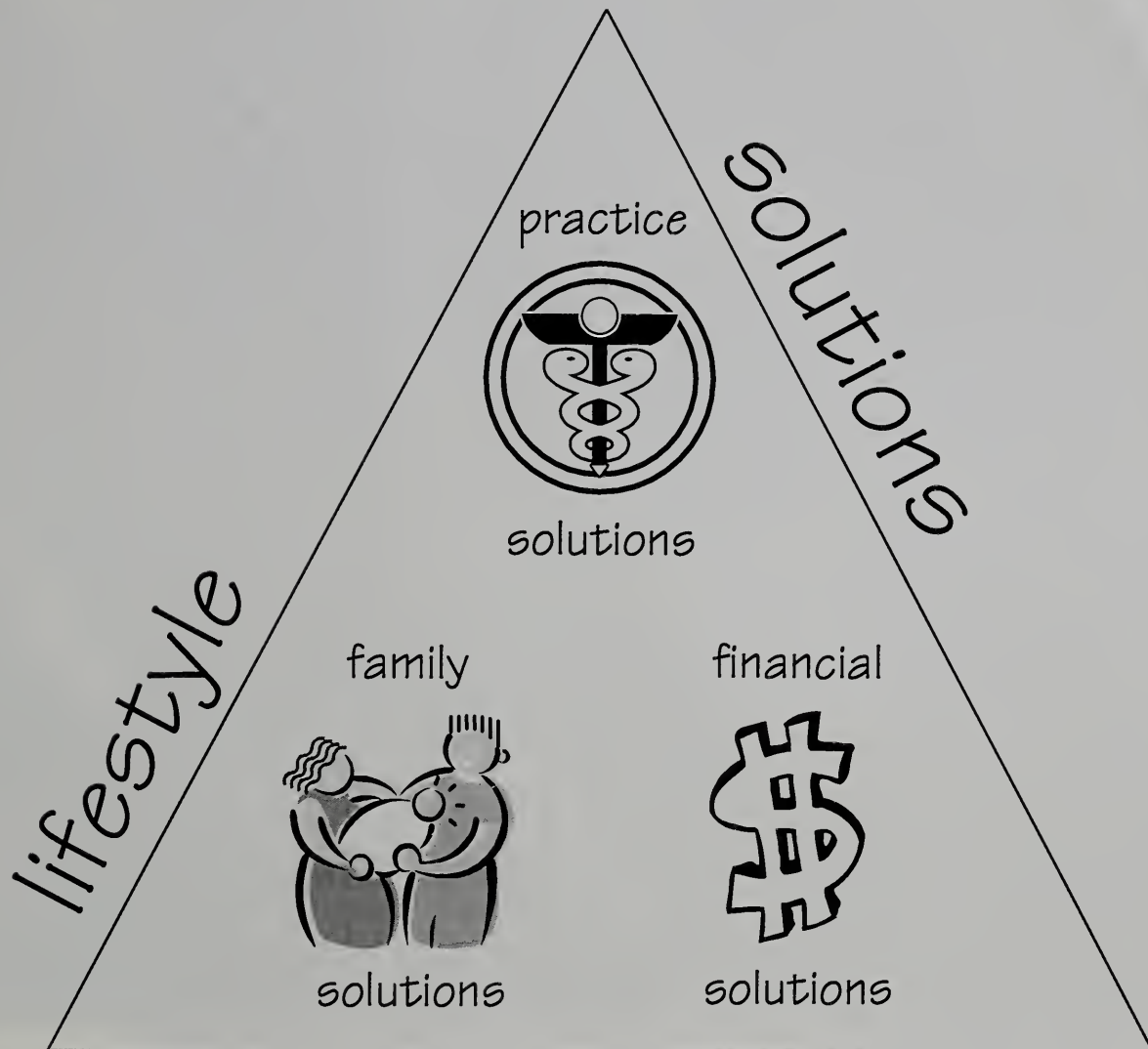
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IPMA is among the oldest continuous medical teaching assemblies in North America, founded in 1916 by physicians from Iowa, Illinois and Wisconsin. Physician from these three states make up its board of directors. This year's Iowa trustees are Dr. John Anderson, Boone; Larry Goetz, Creston; and Donald Rodawig, Spirit Lake. IPMA president-elect is John MacIndoe. The list of past presidents reads like a who's who of medicine, including such luminaries as William J. Mayo, Charles W. Mayo, George W. Crile, Frank H. Lahey and Alton Ochsner.

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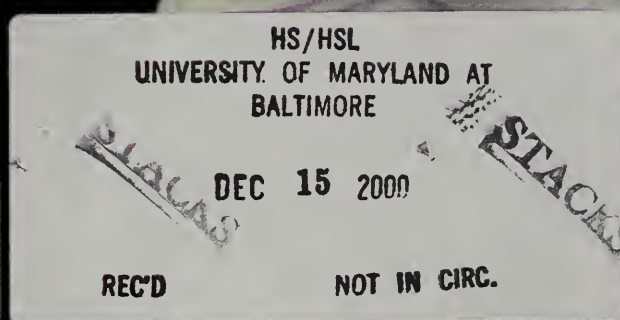
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50 Years

What's wrong with this picture?

Iowa's Medicare: High in quality, low in reimbursement — page 18



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Licensure backlog is improving at the BME / page 6

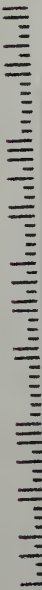
Medicare payment in Iowa flunks the 'smell test' / page 7

Your specialty representative on the IMS legislative committee / page 8

'Hot Zone' author will terrify you at 2001 IMS Annual Meeting / page 10

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Iowa**Medicine**

Published by the Iowa Medical Society

November/December 2000

Vol. 90/6

This month's feature: **page 18**



COVER STORY

Iowa Medicare

A recent HCFA study showed Iowa physicians are providing some of the highest quality care to Medicare patients but our rates of reimbursement are abysmal compared with other states. How did Iowans get stuck at the bottom of the reimbursement ladder? *(First of two parts)*

IMS CORE PURPOSE

To assure the highest quality health care in Iowa through our role as physician and patient advocate

WHAT'S INSIDE

6

What's going on at the BME?

In the not-too-distant past, there was lots of concern over physician licensure delays in Iowa. Today, licensure and license renewals are moving faster and 60% of backlogged investigative cases will be reviewed by the end of 2000. Read about a recent meeting of the Iowa Board of Medical Examiners and the IMS Executive Committee.

7

Flunking the smell test

Iowans pay the same taxes as people in other states, but we are at the lowest rung of the ladder in Medicare reimbursement to Iowa's seniors. Yet, Iowa's Medicare recipients are receiving the highest quality care. The root problem? Large states control Congress and they like the system the way it is.

9

Testing kids exposed to drugs

In Iowa, presence of an illegal drug in a child can be considered child abuse. Though physicians have statutory immunity for good faith testing and reporting, many physicians remain apprehensive about the legal ramifications.

10 His message will terrify you

Richard Preston, author of the best-selling novel "The Hot Zone," will speak at the April, 2001 IMS Annual Meeting. His presentation on biological terrorism and the spread of new viruses has gotten rave reviews from around the country.

15 Costly (and preventable)

Experts digesting the IOM report "To Err is Human" say errors in prescribing, transcribing, dispensing and administering medication are the leading culprit. They also dominate malpractice claims against physicians.

30 New trauma care system

Iowa's new trauma system is designed to match the injured patient's needs to existing Iowa resources. The new system will be operational this January.

31 Patient safety press conference

The IDPH and the University of Iowa School of Public Health have been awarded a \$500,000 grant to identify patient safety problems in Iowa's health care system.

OTHER FEATURES

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Your specialty is represented

How is the IMS advocacy agenda created? The IMS Committee on Legislation plays a key role. Look on page 8 for the name of the physician representing your specialty on this committee.



the Iowa Medicine team

IMS president

Sterling Laaveg, MD

Executive editor

Michael Abrams

Managing editor

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Production coordinator

Tina Stoner

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IMS advocacy meeting

QUESTIONS for IBME

The IMS Executive Committee met recently with three physician members of the IBME and IBME Executive Director Ann Mowery. According to Ann Mowery, licensure and license renewals are moving faster, with 90 applications currently in-house (compared with 245 last December). Dr. Mowery said 800 (of approximately 1,200) backlogged investigative cases will be reviewed this year.

Other issues raised by IMS officers included:

1) *What does the IBME report to the National Practitioner Data Bank?* The IBME is required by law to report any "adverse action" to the NPDB. Nothing is reported until a case is decided. Jeanine Freeman, JD, IMS vice president of public policy, said it is problematic for Iowa physicians if a case is closed with a letter of warning, and that is reported to the NPDB. IBME representatives indicated reports in those cases are not filed with the NPDB.

2) *How is the IBME interpreting the Iowa Code regarding reporting of malpractice actions?* Currently, the IBME receives a report when a malpractice case is filed, and then reviews the case. In light of backlog in other areas, IMS representatives felt it would be more efficient for the IBME to delay reviewing the cases until they are decided.

3) *Will the IBME revisit reporting rules on impairment?* Dr. Sterling Laaveg, IMS president, said the IBME's strict interpretation of the rules has "effectively ended" the IMS mentoring program for troubled physicians. IMS physicians expressed concerns of doctors who know of a colleague suffering from a condition that could (but has not) become an impairment. Uncertainty surrounding reporting obligations and fears of sanction for not reporting are impediments to assisting troubled physicians still practicing safely. IBME board members said a distinction is drawn between a physician trying to help a troubled colleague and one covering up. Dr. Laaveg asked the IBME for a written statement to that effect.

ALL CHILDREN should have coverage

How can more Iowa kids be signed up for the Healthy and Well Kids in Iowa (HAWK-I) program? Answering that question is the challenge of the Covering Kids Now Task Force.

The task force identified key policy changes that would improve Iowa's Healthy and Well Kids in Iowa (HAWK-I) program and made recommendations to the state. Legislators debated those recommendations during the 2000 Gener-

al Assembly and approved eligibility limits to 200 percent of the federal poverty level for HAWK-I.

The Iowa Medical Society is coordinating the task force through a Robert Wood Johnson Foundation Covering Kids Grant to the Iowa Department of Public Health. For more information, contact Denise Hill, JD, at the Iowa Medical Society (800) 747-3070 or (515) 223-1401.



Does it **PASS** the **SMELL TEST?**



Medicare payment for Iowa's seniors is unfair and frustrating. In a word, it stinks.

by Sterling Laaveg, MD

Iowa receives \$3,865 per Medicare patient annual benefit, which is third from the bottom in the United States. Most large states receive almost twice as much. The U.S. average is approximately \$5,400. There are 92 Medicare payment localities. Iowa is tenth from the bottom in reimbursement.

The Minnesota Senior Federation says the cost of providing patient care varies no more than 15 percent from state to state. Large states such as New York or Florida give seniors enrolled in Medicare HMOs prescription drug, dental, vision and hearing services as part of their benefit package.

In the October 4, 2000 *JAMA* article, "Quality of Medical Care Delivered to Medicare Beneficiaries," six medical conditions were reviewed on a state by state basis for compliance with quality indicators as outcome measures. The conditions were acute myocardial infarction, breast cancer, diabetes mellitus, heart failure, pneumonia, stroke. Iowa scored eighth in the nation.

Iowans pay the same taxes as the rest of the U.S. Iowa seniors receive excellent health care coverage. How can there be such a disparity in reimbursement that we are on the lowest rung of the Medicare system?

There is something terribly wrong with this picture.

Employers and labor are tired of paying indirect "taxes" due to increased premiums as the result of cost shifting to make up for low Medicare and Medicaid payments. They are pressuring Wellmark, Principal and

John Deere health insurance companies to lower their premiums.

The IMS staff, your IMS Board and your IMS leadership discuss this inequity each time we meet with our U.S. congressmen. They try to change the reimbursement, but this is representative government at its worst. The large states have the numbers in Congress to control Medicare reimbursement, and they have no intention of developing a more equitable payment system.

Self-interest? Yes. Unfair? Yes. Frustrating? Yes.

What can you do? Talk to your Congressmen about this issue. Inform employers and labor leaders about this problem. Tell your patients they are not getting a fair return on their tax money.

Does this pass the "Smell Test"? No, It really stinks.



Dr. Laaveg is an orthopaedic surgeon in Mason City and president of the Iowa Medical Society.

Your **specialty** is REPRESENTED

IMS Committee on Legislation

When Iowa lawmakers adjourn, IMS advocacy switches to preparing the IMS legislative agenda, issue identification with specialty medical societies and candidate interviews.

There have been two meetings of the IMS Committee on Legislation. The committee's job is to make recommendations regarding the advocacy agenda.

Following are members of the committee and the specialties they represent:

RADIOLOGISTS
Eric Brandser, MD

PLASTIC, RECON. SURG
John Canady, MD

MEDICAL DIRECTORS
Keith Garber, MD

CARDIOLOGISTS
Timothy Hart, MD

OPHTHALMOLOGISTS
Todd Heilskov, MD

REHABILITATIVE MEDICINE
Kurt Hoppe, MD

VASCULAR SURGEONS
Alan Koslow, MD

ORTHOPAEDISTS
Allen Lang, MD

ONCOLOGISTS
Brian Link, MD

PATHOLOGISTS
Ed Loeb, MD

FAMILY PHYSICIANS
David Carlyle, MD
Brian Melhaus, MD
Gerry Stanley, MD

SURGEONS
Joseph Lohmuller, MD

DERMATOLOGISTS
Randall Maharry, MD

COUNTY MED. EXAMINERS
Art McMahon, MD

ALLERGY, IMMUNOLOGY
Edward Nassif, MD

EMERGENCY PHYSICIANS
Tim Peterson, MD

PSYCHIATRISTS
Mark Preston, MD

PEDIATRICIANS
Rizwan Shah, MD

OTOLARYNGOLOGISTS
Tom Simpson, MD

OB/GYN
Deborah Turner, MD

ANESTHESIOLOGISTS
Greg Utesch, MD

INTERNISTS
William John Yost, MD

UNIVERSITY OF IOWA
Richard Nelson, MD

UNIV. OF IOWA STUDENT
Celeste Capers, M-3

MEDICAL GROUP MANAG.
Bob Mason

IMS ALLIANCE
Tess Young, JD

(AT LARGE)
Edwin Castaneda, MD
Clarence Denser, Jr, MD
Thomas Gellhaus, MD

(CO-CHAIRS)
Kevin Cunningham, MD
Judith Dillman, MD

Local races are important, too!

The presidential race is in the national spotlight, but don't forget to pay attention to your local races and congratulate the victors! Meet with your legislators, ask for their support, offer yours, focus on patient care issues. The IMPAC Board has identified legislators likely to hear medicine's message. Contact Jen Davis at IMS for local information.

WHAT ARE THE ISSUES?

MEDICAID — IMS won a long-overdue increase in reimbursement last year, coupled with RBRVS implementation and assurance of annual payment increases consistent with Medicare. The integrity of this payment system must be preserved.

ASSIGNMENT OF BENEFITS — The IMS Board voted to take this issue back to the legislature to protect patients' right to assign insurance benefits to their doctors.

MENTAL HEALTH/SUBSTANCE ABUSE PARITY — IMS supports parity; there are rifts

among lawmakers and the governor.

SCOPE OF PRACTICE — Direct entry (lay) midwives still want state recognition; some nurse midwives want to eliminate state requirements for physician involvement; physician assistants seek more practice independence; optometrists want authority to use an open list of pharmaceuticals; dentists oppose pediatricians giving simple fluoride treatment to Medicaid children these dentists are not seeing.

PROMPT PAY — The insurance commissioner has agreed with IMS and will ask the legislature for a prompt payment law.

CHILDREN'S HEALTH — A bicycle helmet law for children under 15, mandated use of personal flotation devices on boats for children 18 and under, and continuous eligibility for all Medicaid children.

PUBLIC HEALTH — Including greater restrictions on smoking in public and continued dedication of Iowa's tobacco settlement dollars for health care.

TESTING Drug-Exposed



Can physicians test minor children for illegal drugs?

by Jeanine Freeman, JD

Presence of an illegal drug in a child as a consequence of acts or omissions of a person responsible for the child is child abuse in Iowa. Hospitals and physicians suspecting such abuse often fear the legal issues of testing the child.

If a physician discovers effects of an illegal drug in a child, or if the physician determines through examination of the natural mother the child was exposed in utero, the physician may, but is not required to, perform a medically relevant test on that child. Parental consent is not required, although ordinarily it is advisable to inform the parent. The law does not grant authority to test the mother absent her consent.

Physicians must report pos-

itive test results to the Department of Human Services; a knowing and willful failure to report is a simple misdemeanor. The Department is to conduct an assessment to determine if the child has been abused and, if so, to recommend intervention. Physicians must cooperate with the assessment process. Physicians should identify the person as a DHS investigator and release only medical records of relevance.

DEFINITIONS:

Child — any person under the age of 18
Medically relevant test — a test that produces reliable results of exposure to an illegal drug, including a drug urine screen test

Statutory immunity is afforded physicians for good faith compliance in testing, reporting and cooperating with a follow-up assessment.

Hospitals should adopt policy for medically relevant testing of children consistent with Iowa law. The Council on Chemically Exposed Infants and Children is drafting suggested policy, includ-

ing indicia for maternal and infant exposure and chain of custody protocol when a test is performed.

Iowa's testing law is focused on children exposed to drugs due to the acts or omissions of their caretakers. A positive test result obtained prior to the birth of a child, however, shall not be used for the criminal prosecution of a parent.

By way of contrast, a South Carolina case now before the U.S. Supreme Court challenges a hospital's policy to test the urine of pregnant mothers and to report positive test results to law enforcement. Those patients were given a choice: agree to treatment or be arrested for distributing drugs to their unborn child. Some were arrested shortly after the birth of their babies, placed in handcuffs at the hospital and taken to jail. The AMA filed an amicus brief to inform the Court of the ethical and treatment positions of the medical profession.

The AMA before the US Supreme Court—"Drug abuse is a disease that requires treatment and education. It cannot be cured merely by an exercise of self-discipline, nor can it be cured by subjecting addicts to criminal penalties. ... Attaching a threat of arrest to a drug testing policy also weakens the physician/patient relationship. ... Knowing that discovery of drug use may lead to arrest, a patient will avoid treatment altogether, or, at a minimum, will be reluctant to disclose such drug use."



Jeanine Freeman is vice president of public policy and advocacy for the Iowa Medical Society. Information in this column is not intended to be legal advice. Call your attorney with specific concerns.

Disease knows no BORDERS

At the World Federation of Public Health Associations in Beijing, China, AMA President Randolph Smoak, Jr., MD, sounded a

warning that disease is spreading faster and further than ever before, posing greater challenges for treatment and prevention than at

any time in human history.

"Disease knows no borders, and neither must we," Dr. Smoak said. "A disease outbreak in Africa or Asia or North America is everyone's concern — not just as humanitarians — but as physicians dedicated to health in our own countries."

He pointed to the "West Nile Virus" as a disease experts believe traveled easily by airplane from the River Nile to the banks of New York's Hudson River.

"The case of West Nile Virus points out the greatest concern medical professionals face with regard to the global disease burden: Where once an epidemic could only move as fast as man could walk, microorganisms today move with supersonic speed."

Dr. Smoak issued a call to his colleagues to work hand in hand, using all the new technologies available to them. Dr. Smoak cited a number of AMA initiatives aimed at making the fight against disease a global effort, including a new international AMA membership program, allowing physicians from around the globe to benefit from telemedicine training.



"He introduced the world to the threat of Ebola and other rain forest viruses."

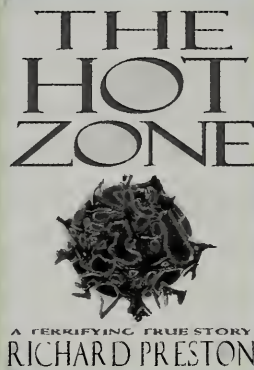
'Hot Zone' author to speak at 2001 IMS Annual Meeting

The author of two best-sellers that have taken the world by storm will be the headline speaker at the IMS 2001 Annual Meeting Saturday noon, April 21 at the downtown Des Moines Marriott.

Richard Preston wrote the "The Hot Zone," an international best-seller that caused a frenzy of media coverage and inspired several fictional adaptations. Preston's second

novel, the "Cobra Event," centers on the threat of biological terrorism. Preston will tell the gripping story-

behind-the-story, a shocking account of 21st century warfare. He shares the inside story of how he uncovered the facts no one wanted to admit. His program is a rare journey into biological espionage and military intelligence.




Interested in running for an IMS office?

The IMS Nominating Committee will meet by conference call on Wednesday, November 15 to begin reviewing officer positions up for election in 2001. If you are interested in running for an IMS office, contact Ed Whitver

at the Iowa Medical Society, (800) 747-3070.

The elections will be held at the IMS Annual Meeting April 21-22 at the Des Moines Marriott. Siroos Shirazi, MD chairs the nominating committee.



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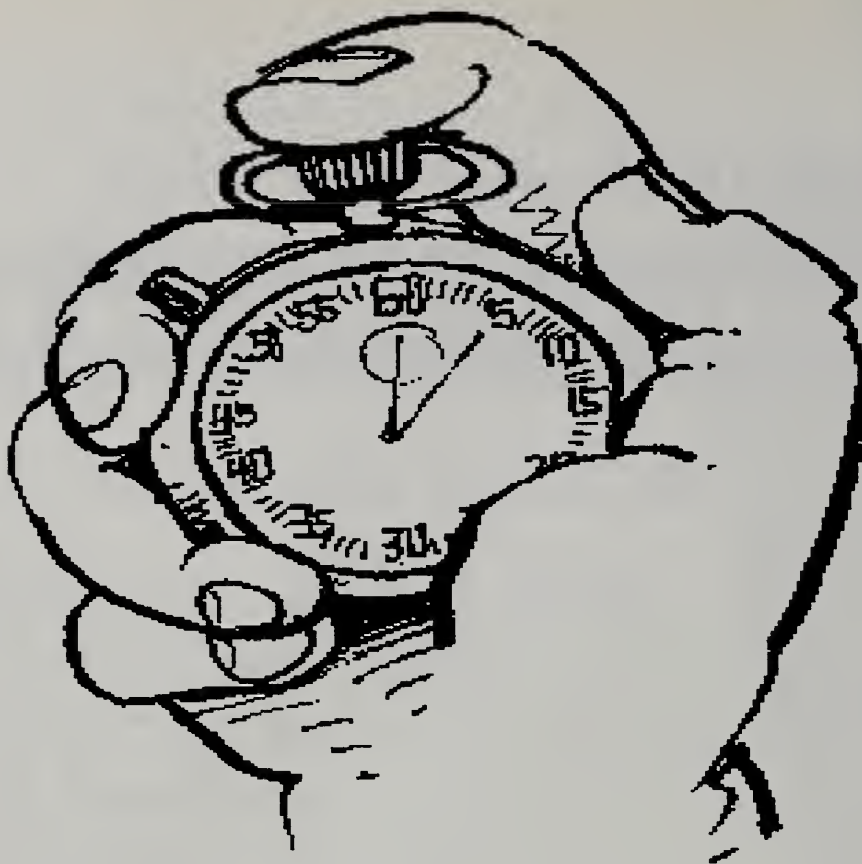
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IOWA PHYSICIAN distinctions & AWARDS

THE ROAD TO BECOMING A PHYSICIAN received the "Shoestring Award" from the Association of American Medical Colleges Group on Institutional Advancement. The brochure, produced by the University of Iowa College of Medicine and IMS, outlines the process of physician training for the general public. Copies are available by calling Becky Bales at IMS (800) 747-3070.

JULIA GOODIN, MD, Iowa's chief medical examiner, was elected to the Board of Directors of the National Association of Medical Examiners.

KENNETH SCHULTHEIS, DO, represented IMPAC at the AMPAC Board of Directors Federation meeting.

NANCY ANDREASEN, MD, PHD, has been awarded the Lieber Prize for outstanding research in schizophrenia.

NORMA HIRSCH, MD; SHANE SCOTT, MD; DAVE HENERSON, MD; and **RICHARD DOBBYNS, MD**, were featured on IPTV following the Bill Moyers' special, "On Our Own Terms."

DENNIS BOATMAN, MD, has received the Hancher-Finkbine Alumni

Medallion, one of the highest honors given by the University of Iowa.

NATHAN JOSEPHSON, MD, has been appointed director of the University of Iowa Medical Education Program in Des Moines.

LYNN STRUCK, MD, received the 1999-2000 Preceptor of the Year award from Broadlawns Medical Center.

BRUCE HUGHES, MD, was appointed to the Board of Directors of the Iowa Board of Medical Examiners.

RICHARD AVERBACH, MD, joined University of Iowa Family Care in Ottumwa.

DAVID DRAKE, DO, joined Richard Preston, MD, PC, in practice.

TANYA TEGGATZ, MD; KENNETH KNUDTSON, MD; SUDHAKAR MISRA, MD; and **SUNNY ZHANG, MD, PHD**, have recently joined Mercy Medical Center-Cedar Rapids.

In the last Iowa Medicine, Mercy Care Community Physicians was inadvertently omitted from the list of Iowa clinics with 100% IMS membership.

DECEASED MEMBERS

ROBERT PFAFF, MD, 82, life, urology, Dubuque

FREDERICK STARK, MD, 87, life, neurology, Sioux City, August 9, 2000

CHARLES MAPLETHORPE, MD, 82, life, family practice, Toledo, August 12, 2000

IMS welcomes NEW MEMBERS!

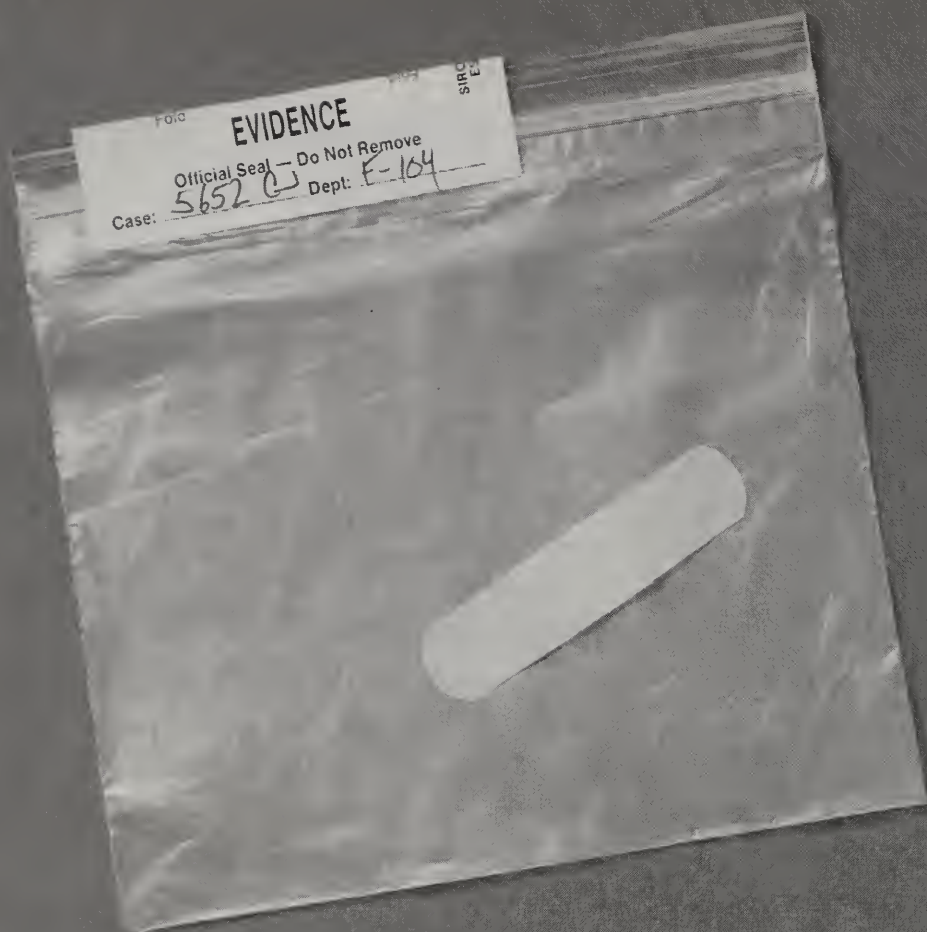
Timothy Bowers, MD, Dubuque
Mark Runde, MD, Dubuque
Sujatha Prasad, MD, Oelwein
Daniel Mansfield, MD, Decorah
Anthony Ellis, DO, Lake City
Darron Jones, MD, Mason City
Lynde Knowles-Jonas, MD, Mason City
Brian Link, MD, Iowa City
Bruce Pfohl, MD, Iowa City
M. Sue O'Dorisio, MD, Iowa City

Stacy Thompson, MD, Iowa City
Vernon Varner, MD, Iowa City
Edeliro Escobar, MD, Fort Madison
James Putman, MD, Bettendorf
John Patton, MD, Davenport
Louis Madison, MD, Des Moines
Douglas Schulte, MD, Des Moines

NEW RESIDENTS
Monica Burgett, DO
Michael Farris, MD

Angela Schwendinger, MD
Karl Treiber, DO
Matthew Smith, MD
Robert Tolentino, MD
Mikka Appel, MD
Keri Mounce, MD
Anji Neil, MD
Matthew Neil, MD
Todd Wenck, MD
Gregory Vandigo, MD

Members of the Iowa Medical Society join in welcoming the following new members into a progressive state medical association. The care purpose of the IMS is to assure the highest quality health care in Iowa through our role as physician and patient advocate. Each new member is encouraged to join other IMS members at both local and state levels in achieving these goals.



*e*xhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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Medication errors: **costly** AND **PREVENTABLE**

Media coverage of the Institute of Medicine (IOM) medical errors study has alerted the public and the medical community to patient safety. But what are the real issues behind the sensationalism of the study?

The IOM study reinforces that preventable medical errors do occur and focuses attention on medication errors. MMIC's data shows medication errors also dominate malpractice claims filed against physicians. As reflected in the IOM study, mistakes in prescribing, transcribing, dispensing and administering medication are both frequent and expensive.

Studies done by the Physician Insurers Association of America (PIAA) have evaluated the types of malpractice claims resulting from medication errors. Four errors account for the majority of the claims:

1) Incorrect or inappropriate

ate dosage

2) Medication inappropriate for the condition

3) Failure to monitor for drug side effects

4) Communication failure between physician and patient

Risk management strategies for medication errors:

- Include the indication for a medication in the order
- Do not use name abbreviations or chemical symbols

• Write all orders using the metric system

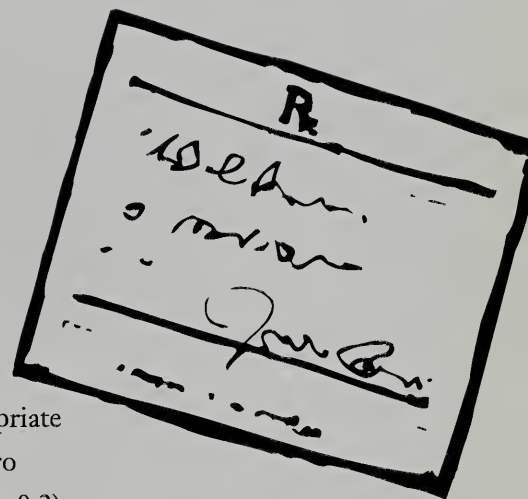
• Specify concentrations where appropriate

• Use a leading zero before a decimal (e.g., 0.2)

• Avoid using easily confused abbreviations (q.i.d. vs. q.d.)

• Consider using computerized prescribing equipment

• Be alert to look-alike and sound-alike drug names



how we learn

CONNECT for learning

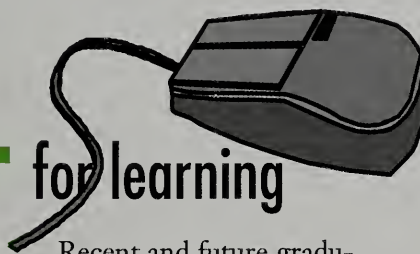
Just a decade ago it was unusual for a practicing physician to regularly use the Internet. While most physicians had office computers, the exclusive functions of the machines were to support the business of practice.

Now it is a different story. Within the last year an alumni e-mail directory and Web site have been created for the College of Medicine at the University of Iowa. Over 3,500 subscribers use that Web site for information access.

Recent and future graduates of medical school are as facile in searching the Net as their forebears have been in using the library. The library has moved into their offices and homes.

Patients also have access to much of the same information and are particularly motivated to obtain knowledge of recent advances in the care of disease.

There is every reason to be e-literate. The URL is just another tool in our doctor's bag.



This column is provided by Midwest Medical Insurance Company especially for Iowa physicians. For more information, call Lori Atkinson, MMIC risk management manager, at (800) 798-9870 or (515) 223-1482.

This column is written by Dr. Richard Nelson, executive dean, University of Iowa College of Medicine.

A Decade of DECISIONS



Ed Green is a senior financial analyst with Foster Capital Management, a fee-only financial planning and investment management firm located at IMS headquarters, (800) 798-1012.



Reed Rinderknecht, CFP, is director of client relations with Foster Capital Management. For a free initial consultation or more information about their fee-only services, please contact him at (800) 798-1012.

Crucial decisions are made in the first five years before retirement and the first five years of retirement.

by Ed Green

An article regarding retirement planning from the *Journal of Financial Planning* focused on the importance of decisions made in the five years before retirement and the first five years of retirement. This time period was referred to as the “Decision Decade.” Decisions made during this time period have a significant effect on the success of your retirement.

The five years before retirement set the stage for crucial decisions. The problem is, it is in this five-year period of time most people experience the greatest freedom from financial stress and

worries. Income is most likely at its highest and expenses may have decreased due to debt reduction and the elimination of financial responsibilities such as college tuition or children living at home. The result is a widening expense and earnings gap. These are indeed good times.



But herein lies the problem. Suppose the couple chooses to spend the surplus. After all, they worked hard and they deserve a better home, new cars and a grand vacation. The hidden impact of this drastic change in lifestyle is the impact it will have on retirement lifestyle expectations. The goal for

most retirement planning is to have a lifestyle similar to that enjoyed just before retirement. If spending patterns increase dramatically before retirement, they tend to increase the budget throughout retirement.

The second critical period for decision making is the first five years of retirement. This is the “Whoopie” stage in which major decisions are made. Many of these decisions are appropriate and well deserved. However, making these decisions without understanding the long-term significance can affect your retirement. Understanding issues like health, life expectancy, residence options, inflation, investment returns and risk are critical in the planning process.

You have worked hard to create financial security. Don’t destroy that security by entering the “Decision Decade” uninformed and ignorant of obstacles and landmines.

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Medicare in Iowa

HIGH quality LOW payment

Medicare payment to Iowa's seniors proves excellence is not always rewarded.

If the Health Care Financing Administration reimbursed Medicare services based on its own standards of quality care, Iowa would do very well indeed.

In a study released last month, HCFA reviewed care provided to Medicare beneficiaries for six clinical areas including heart attacks, breast cancer, diabetes, heart failure, pneumonia and stroke. Measured according to quality indicators for each condition, Iowa's care of Medicare patients ranks 8th among 52 states and territories. Yet, in 1997, (the last

year for which figures were available), Iowa beat only one state — lonely North Dakota — in average payment per Medicare patient (see box on opposite page.)

If you think this is nonsensical, consider Louisiana, which ranks 49th in quality of care and, at \$7,886, is second highest in the nation in average per patient reimbursement. Is it any wonder

Iowa — 8th in QUALITY

HCFA's Medicare quality rankings by state

New Hampshire 1	Wyoming 12	Alaska 23	Dist of Col 34	Texas 45
Vermont 2	Washington 13	Rhode Island 24	S. Carolina 35	Illinois 46
Maine 3	Delaware 14	South Dakota 25	Kentucky 36	Georgia 47
Minnesota 4	Montana 15	Nebraska 26	Kansas 37	New Jersey 48
Massachusetts 5	Virginia 16	Maryland 27	Nevada 38	Louisiana 49
Connecticut 6	N. Carolina 17	Michigan 28	Tennessee 39	Mississippi 50
North Dakota 7	Pennsylvania 18	Missouri 29	Florida 40	Arkansas 51
Iowa 8	Arizona 19	Indiana 30	California 41	Puerto Rico 52
Colorado 9	Utah 20	New York 31	Oklahoma 42	
Oregon 10	Idaho 21	New Mexico 32	W. Virginia 43	
Wisconsin 11	Hawaii 22	Ohio 33	Alabama 44	

This story was written by Chris McMahon, vice president of communications, with research assistance from Jennifer Davis, manager of legislative affairs.

Iowa physicians are looking at these numbers and scratching their heads?

"Something is definitely wrong with this picture," commented Sterling Laaveg, MD, IMS president, in a recent press release. "Iowa's Medicare patients are getting a raw deal."

When you couple low Medicare reimbursement with Iowa's burgeoning elderly population, you have another serious problem.

"Recruitment and retention of quality physicians is made that much harder by subpar reimbursement," comments Ed O'Neill, MD, a Dubuque surgeon. "We have heard this from physicians we have tried to recruit from other states."

"The effects on the economies of these areas is immense and much more far reaching than just the disparity in Medicare payments," says another Iowa physician.

HOW LOW CAN WE GO?

Part B payment has changed dramatically since the inception of the Medicare program in 1965. With each change, disparities between urban and rural areas have continued.

Three major factors led to Iowa's low Medicare reimbursement:

1) CPR (customary, prevailing and reasonable), was the original Medicare physi-

cian payment system.

Regional rural/urban cost differences were allowed for the same procedure. These costs were frozen in the 1970s and became the basis for reimbursement up until 1992. During this time, two and threefold differences in Medicare payment for the same service developed.

2) The 1992 implementation of the Resource Based Relative Value System (RBRVS), which was geographically adjusted based on differences in physicians' rent, wages of office staff, professional liability insurance and cost of living.

3) The federal government's under-funding of Medicare since the program's inception.

GROWING DISCREPANCIES

Initial physician payment discrepancies through 1980 grew out of the reimbursement system which was based on "customary, prevailing and reasonable."

CPR was designed to pay for physicians' services according to their actual fees, with some adjustments to keep government outlays predictable. CPR was similar to the "usual, customary and reasonable" system used by many private insurers.

Wide differences in payment levels began developing among geographic areas and physician specialties.

The federal government tried to stem the increases by

// Recruitment and retention of quality physicians is made that much harder by subpar reimbursement. //

Iowa — bottom in PAYMENT

Average payment per Medicare patient served, 1997

District of Col.	9,161	Tennessee	5,896	N. Carolina	4,919
Louisiana	7,886	Michigan	5,883	Washington	4,879
Massachusetts	7,403	Illinois	5,762	Hawaii	4,801
Texas	7,263	Georgia	5,762	Maine	4,741
California	7,123	Missouri	5,508	Utah	4,734
Alaska	6,813	Delaware	5,504	Wyoming	4,713
New York	6,732	Colorado	5,399	New Mexico	4,661
Rhode Island	6,527	Kentucky	5,339	Wisconsin	4,447
New Jersey	6,487	Ohio	5,327	Idaho	4,316
Florida	6,432	Arizona	5,249	Oregon	4,281
Mississippi	6,264	Indiana	5,202	Nebraska	4,258
Nevada	6,263	S. Carolina	5,127	Minnesota	4,257
Pennsylvania	6,254	W. Virginia	5,096	Montana	4,187
Connecticut	6,154	New Hampshire	5,078	Vermont	4,174
Maryland	6,207	Kansas	5,048	S. Dakota	4,160
Oklahoma	6,171	Virginia	5,065	Iowa	4,027
Alabama	5,995	Arkansas	4,979	N. Dakota	3,856

freezing payment for physician services. Increases to prevailing charges were based on early 1970s costs.

Thus, physician procedural charges from the 1970s became the standard, even though clinical practice and technology costs grew at an even greater rate.

“The RBRVS system has been tinkered with and perverted by lobbies from states that have traditionally been highly reimbursed.”

Rates were also frozen geographically, which placed a double burden on physicians in rural parts of the country. Geographic cost differences received no updates until 1992.

During the 1980s, physicians and the federal government both began pushing for a change to the Medicare Part B payment system, but for their own reasons. Physicians said the CPR no longer reflected the true cost of practicing; many physicians were upset that the geographic discrepancies were outrageously skewed toward urban areas.

The federal government

wanted to control spiraling costs. Because Congress was unlikely to appropriate more funds to bring rural areas in line with urban areas, the payment system was the only possible way of dealing with the discrepancies.

HELLO RBRVS

The January 1, 1992 implementation of the Resource Based Relative Value Scale (RBRVS) was the first major change to Medicare Part B since the program's inception. This new payment system was based on three geographic practice cost indexes (GPCIs) — physician work involved in providing the service, practice expense and professional liability insurance costs. Supposedly, the new system allowed for a much narrower variation among states. However, since each of the components which comprise the system is adjusted for geographic differences in resource costs, urban areas have benefited once again.

However, their perspective is that they, too, are underfunded by Medicare.

The GPCIs are updated every three years. But, changes in the GPCIs do not affect total Medicare physi-

cian payments. Rather, they redistribute payments among localities. Ranking 82nd among 92 payment localities, Iowa clearly has not fared well in any redistribution of funds.

“The RBRVS system has been tinkered with and perverted by lobbies from states that have traditionally been highly reimbursed,” commented one Iowa physician in an email to IMS. “It seems like there should be some constitutional equal protection under the law for Iowans and midwesterners.”

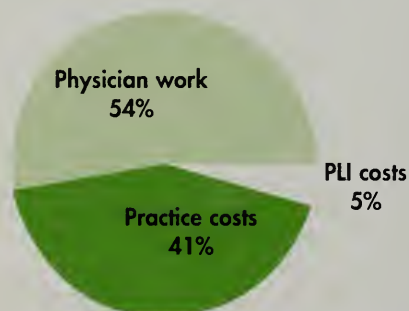
GROSS AND UNEQUAL

Iowa providers are not the only ones complaining about the inequitable Medicare payment system. An editorial in a recent *Seattle Times* complained that Washington state residents are being shortchanged by the federal government.

The editorial cites a 1999 study of Medicare by Dartmouth University Medical School confirming the unjustifiable geographic disparity in Medicare payments: “Spending is simply higher in some geographic areas than in others, for reasons that have little to do with need or demand for care,” said the report. “Similarly, little of the variation is explained by regional differences in prices.”

In July, US District Court

COMPONENTS OF THE MEDICARE RBRVS



- Elements of physician work
- time required to perform the service
 - technical skill and physical effort
 - mental effort and judgment
 - psychological stress associated with the physician's concern about iatrogenic risk to the patient

Medicare RBRVS: The Physician's Guide

Judge Donald Alsop dismissed a lawsuit filed against HCFA by the Minnesota Senior Federation and supported by the IMS. The lawsuit alleged a violation of the Constitution due to discriminatory rates of Medicare payment.

The judge did not agree that Medicare reimbursement violates the constitution, but he spoke strongly about Medicare's inequities.

"The court's decision is not to be considered a judicial endorsement of a reimbursement system which even the defendants concede results in gross and unequal treatment of senior citizens," said Judge Alsop. "It is hoped those with ultimate authority to remedy this wrong — indeed those who created it —

will promptly recognize the injustice they have created and enact legislation to correct it."

The Minnesota Senior Federation, an advocacy organization for seniors, is appealing the decision and has vowed to organize consumers nationwide to change the system.

THE HMO FACTOR

Medicare patients in urban states benefit from geographic differences in reimbursement, but their advantage over Iowa's seniors doesn't stop there. In 1999, the reimbursement rate for Medicare managed care plans in parts of New York, Texas and Louisiana ranged from \$750 to nearly \$800 a month per patient, over twice as much as the average Medicare patient in Iowa.

In urban states where medical costs are high, reimbursement is also high enough that Medicare HMOs can offer plans without a premium. Consequently, in urban states, a majority of Medicare patients are in managed care plans. They get prescription drug coverage, vision and hearing services and a plethora of other benefits, sometimes for no annual premium and no copayment.

Only a handful of Iowans are in Medicare managed care plans and that is not likely to change. During the past three years, 100 plans

across the country have stopped offering Medicare managed care coverage in certain counties, while another 90 have stopped offering such plans entirely. The reason? Inadequate reimbursement. Medicare administrators are alarmed at the trend, but note that only Congress can change the payment system.

DOES QUALITY COUNT?

Meanwhile, Iowa physicians continue providing high quality care to Medicare patients who aren't getting a fair return on their federal tax dollars. However, according to HCFA officials, there is no effort contemplated to link quality of care to reimbursement rates.

"The prevailing view at HCFA is that we just don't know enough about the relationship of quality and reimbursement," explains Robert Epps, provider liaison officer in HCFA's Kansas City Regional Office. "If we did link them, there would probably be more of a tendency to reduce payments to the states at the high end of the scale."

// It is hoped that those with ultimate authority to remedy this wrong will promptly recognize the injustice they have created and enact legislation to change it. //

What's next?

In next month's *Iowa Medicine*, look for part 2 of our story on inequitable Medicare reimbursement. We'll have more comments from HCFA, our congressmen and AARP about what can (or can't) be done.

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Less invasive surgery for **AORTIC ANEURYSMS**

University of Iowa Health Care surgeons are now certified to perform a minimally invasive procedure to treat abdominal aortic aneurysms (AAA).

The traditional treatment for repairing aneurysms requires a large abdominal incision, cutting through layers of muscle and moving aside the internal organs to get to the diseased aorta.

The aorta is clamped on either side of the aneurysm and the weakened section replaced with a graft.

"Because many of the patients requiring this form of surgery are older, the traditional open surgery can prove to be a big stress to system and full recovery can be a slow and painful process," said Jamal Hobal-

lah, MD, UI associate professor of surgery.

The new procedure is much easier on patients. Rather than opening the patient's abdomen, two small incisions are made in the groin area and a catheter is used to deliver one of two devices, called endografts, into the aorta. The endograft is guided through the blood vessel to the site of the aneurysm. The new self-supporting grafts do not require sutures to stay in place.

The UI has been involved in the development of techniques for endovascular surgery over the last decade, but have been cautious about offering the treatments to patients.

From UI Health News, July 31, 2000

He **ERASES** history



They call him Dr. Delete. Dr. Christopher Arpey spends his days erasing history. Using cutting-edge technology, he carefully blots out colorful mileposts from his visitors' limbs and nether regions.

Arpey, a dermatologist at the University of Iowa Health Care Clinic, removes tattoos. Business is good.

The fad is particularly strong in the Midwest, which Des Moines tattoo artist Lee Buchanan calls "a tattoo mecca."

Arpey's clients have stories that are as varied as the size and locations of their imbedded-ink designs. But the bottom line is that they're willing to pay five times more than the cost of the tattoo to have it removed.

From Des Moines Register, June 18, 2000.

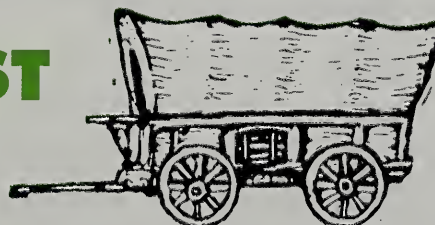
Des Moines hospitals headed **WEST**

Des Moines hospitals, attracted by central Iowa's fastest-growing areas, are looking west for their futures — and for new patients.

Iowa Clinic and Iowa Methodist Medical Center are working together to

build a 17,400 square foot outpatient surgery center in Dallas County.

The new Iowa Clinic and Iowa Methodist venture is to be built just west of the Polk County line, between University Avenue and Westtown Parkway.



The new clinic is scheduled to open in late 2001 or early 2002.

From Des Moines Register, June 28, 2000

U.S. doctors

NOT PULLING WEIGHT in obesity fight

Physicians are simply not talking to their obese patients. With the rate of obese Americans climbing, it is essential physicians began sharing the consequences of obesity with patients and helping them find solutions.

Dr. Randall Stafford, Massachusetts General Hospital and Harvard Medical School, found physicians report obesity in only 38 per-

cent of their obese patients.

The team found that when weight is associated with an obesity-related illness, the



patient is treated more aggressively. But even these patients were counseled about weight loss only half of the time they visited a physician's office.

The authors said there appear to be a number of reasons why physicians have

a difficult time discussing obesity with their patients. Reasons include the belief that counseling patients to lose weight is futile. Follow-up studies have shown after seven years, 95 percent of dieters regress back to their pre-diet weight.

Dr. Diane Eliot, a professor of medicine at Oregon Health Sciences University, says although most physicians take courses on nutrition and obesity in medical school, they become frustrated at not seeing results. Eliot reminds physicians that changing behavior takes time, and recommends that overweight individuals be encouraged to lose weight in small steps.

UPDATE on flu vaccinations

The CDC is encouraging people with diabetes to get their pneumococcal and annual flu vaccinations despite the anticipated delay and shortage. As flu season approaches, the CDC asks for the help of all health professionals to vaccinate people with diabetes as early in the flu season as possible. Health professionals without vaccine should direct people with diabetes to health clinics that have a supply.

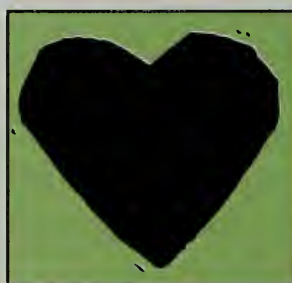
AHA RELEASES

new CPR and ECC guidelines

In an effort to "simplify training by focusing on the most effective aspects of resuscitation," the American Heart Association has released a new set of cardiopulmonary resuscitation (CPR) guidelines.

The International CPR and emergency cardiovascular care (ECC) Guidelines

2000 are designed for everyone and include the most effective methods for treating cardiovascular emergencies.



Surprisingly, research indicates at least 35 percent of lay rescuers are wrong about whether or not a victim has a pulse. The new guidelines recommend that no pulse check be done before administering chest compressions to an unconscious person.

For more information, visit www.cpr-ecc.americanheart.org.

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The ROADMAP to **significance** (part 3)

Imagine you are 90 years old, sitting on a porch, reflecting on your life.

by Jerry Foster

In the first two parts of this series on the search for significance, I discussed two critical ingredients in establishing the foundation for a living a life of impact.

The first was the importance for creating balance in life in the vital roles we live.

The second was the importance of determining your passion in life and walking down a path that has **VISION**.

The third element that is critical is the need to create the picture of your life and how you want to be remembered and what impact you want to have when you are gone.

During the Christmas holiday, my family works on a jig-

saw puzzle in front of the fireplace. It is a wonderful time of laughter and communication. When putting a jigsaw puzzle together, one very important part of that puzzle is required to successfully put that puzzle together. We need the picture. Without it, the construction becomes almost impossible.

The same is true of your life. If we truly want to have impact and want to finish the race of life successfully, it becomes imperative that we have a picture in front of us that describes what finished product should look like.

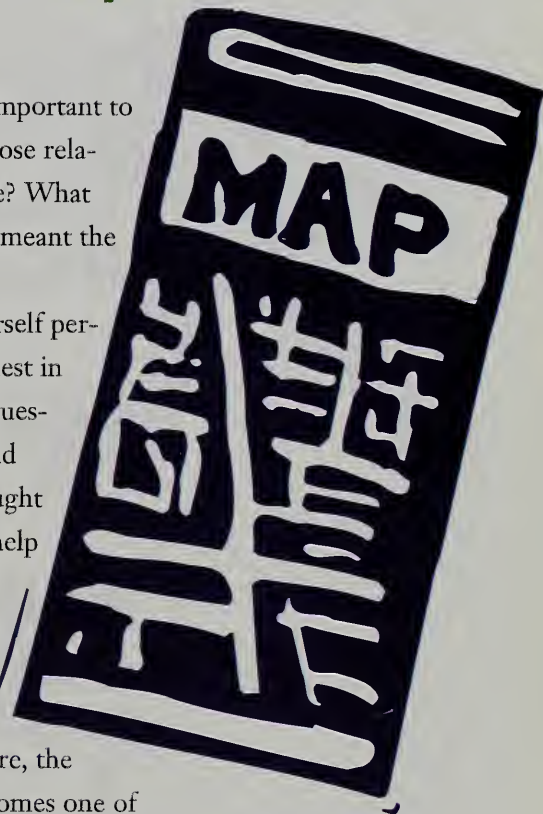
Here is a great exercise that can help you paint the picture of your life. Imagine yourself 90 years old, sitting on a porch reflecting on your life. You have accomplished a lot, but ask yourself these questions: What needs to have happened for you to feel as if your life was meaningful and successful according to your definition of success, not our culture's? What relationships

were most important to you? What did those relationships look like? What accomplishments meant the most to you?

If you give yourself permission to be honest in answering these questions, you may find yourself on a thought process that will help you define what your life should really look like. Once you have painted that picture, the next question becomes one of **ACTION**.

What do I need to do to insure the completion of that picture? Remember these words as you think about your life and its significance.

"The legacy you leave will give testimony to the life you lived."



Jerry Foster is the CEO of Foster Capital Management, a fee-only financial planning and investment management company located at IMS headquarters, (800) 798-1012.

New trauma care system for Iowa

Iowa's trauma care system will be operational January 1, 2001. The need for action was initiated by the



This article was submitted by Timothy Peterson, MD, Bureau of EMS Medical Director.

Iowa Medical Society in 1988 when it recommended the following: develop a voluntary comprehensive injury surveillance system; work toward trauma system development and evaluation; inform physicians about injury and trauma care, and support health safety education on trauma prevention.

The purpose of Iowa's trauma system is to be all-inclusive and match the injured patient's needs to existing Iowa resources.

Iowa's trauma care system focuses on all seriously injured patients and all EMS system health care providers.

The Iowa Department of Public Health is responsible for the development, implementation and evaluation of the Iowa trauma system.

Physician advocacy is needed to ensure the future of Iowa's trauma system. Leadership at the local, regional and state levels is important in these areas:

- Education for hospital medical/clinical staff and administration
- Participation in medical staff multidisciplinary trauma committee peer review
- Provide direction to assure standards of care for ambulance services, hospitals and public health initiatives
- Support public education with a strong focus on prevention, and
- Participation on state planning committees.

All health care providers and the public are encouraged to work together to assure traumatic injury is being addressed proactively. This is best achieved by participation in Iowa's statewide trauma care system.

IMS Health care executives hear about provider relations

The new head of provider relations for Wellmark was guest speaker at a meeting of the IMS Health Care Executives Section. Lyndon Peterson discussed Wellmark's troubled relationship with Iowa providers, citing several factors including recontracting efforts, a new payment system, Wellmark's market strength and waiting times for provider inquiries. Peterson also discussed Wellmark's efforts to defeat the IMS-supported assignment of ben-

efits bill in the 2000 Iowa Legislature.

Other speakers included Rob Tully, chair of the Iowa Democratic Party and Dee Stewart, executive director of the Republican Party of Iowa. Tully and Stewart discussed the upcoming presidential election. Dale Andringa, MD, director of strategic improvement for Vermeer Manufacturing, discussed standardization of health care as a way of ensuring quality and efficiency.



Dr. Dale Andringa spoke to IMS Health Care Executives.

IMS at PATIENT SAFETY PRESS CONFERENCE

Charles Helms, MD represented the Iowa Medical Society at a recent press conference on patient safety called by Senator Tom Harkin and Dr. Steve Gleason, director of the Iowa Department of Public Health (IDPH). The press conference was held to announce that the IDPH and the University of Iowa School of Public Health have been awarded a \$500,000 grant to identify patient safety prob-

lems and find solutions.

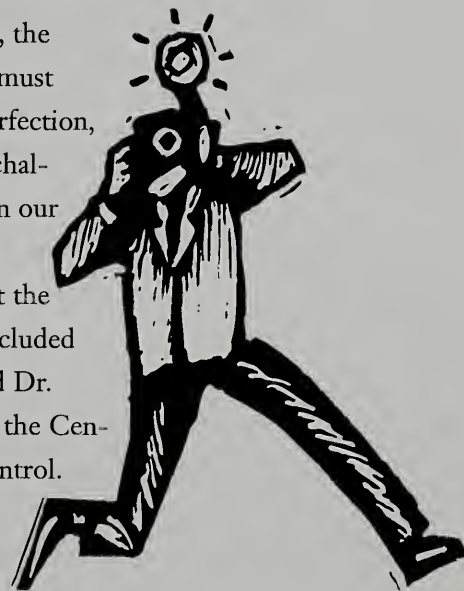
Dr. Helms is chair of the IMS Task Force on Patient Safety.

"We don't yet know the extent of any problems in Iowa," Dr. Gleason told reporters. "I believe any problems are due principally to flaws in the health care system as a whole rather than the result of errors by Iowa's health care providers."

Dr. Helms emphasized that Iowa recently ranked eighth

in a HCFA study of quality of care provided to Medicare patients. "However, the health care system must always strive for perfection, and we accept the challenge of building on our success," he said.

Other speakers at the press conference included Senator Harkin and Dr. Steven Solomon of the Centers for Disease Control.



IMS alliance

RIGHT place, RIGHT time

Legislative activities of the IMSA continue to be a top priority. Tess Young, IMSA legislative chair, noted the issues that will be addressed in the upcoming legislative session: assignment of benefits, mental health parity, Medicaid reimbursement and scope of practice of lay midwifery, physician assistants, optometry and EMS personnel.

At a proclamation signing with Governor Vilsack, I was able to mention that the IMS

and IMSA would appreciate his support with the assignment of benefits bill. The Governor explained he vetoed the bill because he was unsure of the economic impact it would have on patients. He was under the impression that the bill could potentially change the payments or benefits of the patient. Tess Young did a terrific job explaining how the bill would not change benefits and is simple and straightforward.

IMSA legislative plans consist of an e-mail information system addressing legislative issues with our members throughout Iowa. The Alliance will be holding a legislative breakfast on Thursday, January 25, 2001 at the Capitol. This occasion will present the opportunity to address all issues of concern with our legislators and senators. As an Alliance, we will do all we can to continue our support of the IMS on legislative issues.



This article was written by Ann Crouch, IMSA president.

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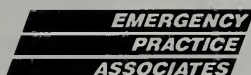
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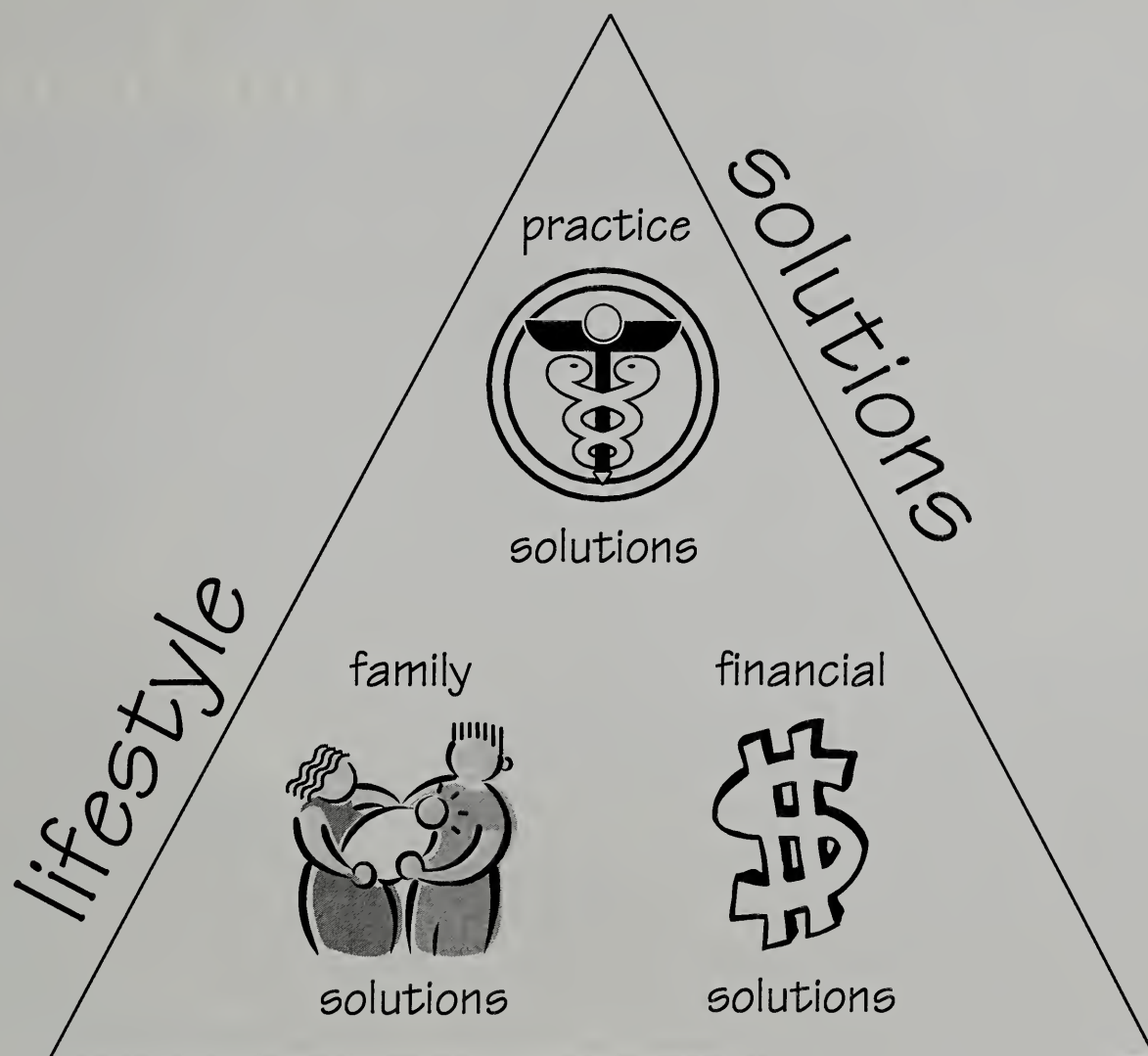
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